PRINTED: 05/17/2011

| | T OF HEALTH AND HUMAN SERVICES | | | FORM APPROVED | |
|---------|--|------------------|--|--|--|
| STATEME | OR MEDICARE & MEDICAID SERVICES ONLY OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | ONSTRUCTION 00 | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | |
| | 155672 | B. WING | | 04/18/2011 | |
| | PROVIDER OR SUPPLIER ON GROVE | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL FARLISLE, IN46552 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| F0000 | REGULATORY OR LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | This visit was for a Recertification and State Licensure Survey. | F0000 | Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact | | |
| | Survey dates: April 11, 12, 13, 14, 15, and 18, 2011 | | conclusion set forth in the statement of deficiencies. This plan of correction is being submitted | l in | |
| | Facility Number: 000427 | | good faith by the | , "" | |
| | Provider Number: 155672 | | facility because it is required | by | |
| | AIM Number: 100275150 | | law. The facility reserves the | e | |
| | Survey Team: | | contest the statement of deficiencies. | | |
| | Sandra Haws, RN TC | | demoioriolee. | | |
| | Toni Krakowski, RN- April 11, 12, 13, 14, and 15, 2011 | | | | |
| | Vicki Manuwal, RN- April 11, 12, 13, 14, and 15, 2011 | | | | |
| | Bobbi Costigan, RN- April 11, 12, 14, 15, and 18, 2011 | | | | |
| | Census Bed Type: SNF/NF: 80 | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Residential: 48 Total: 128

Medicare: 11 Medicaid:43 Other: 74 Total: 128

Sample: 16

Census by Payor Type:

Residential Sample: 7

Event ID:

Y4C611

Facility ID:

000427

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE COMP: 04/18/2 | LETED | | |
|--|---|---|---|---|-------------------------------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | ₹ | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | | |
| | These deficienci Findings cited in IAC 16.2 | es also reflect State n accordance with 410 completed on April 24, | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 0 | ETED |
|---|---|--|-------------------------------|---------------------|---|--|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 31869 C | DDRESS, CITY, STATE, ZIP CODE HICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F0157 SS=D | resident; consult wand if known, notifice representative or a when there is an a resident which respotential for require significant change mental, or psychosocial statuconditions or clinical tertreatment significant in the psychosocial statuconditions or clinical tertreatment significant in adverse consection of treatment for most or dischart facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resupdate the address | is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or actions as specified in | | | | | |
| | Based on record facility failed to notified of a criti in eating by failing shift, and a tempand for failing to regarding holding | review and interview, the ensure the physician was cally ill resident's change ng to eat for an entire erature of 103 degrees notify the physician g insulin for a diabetic ficient practice affected 2 | F01 | 157 | Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact conclusion set forth in the statement of deficiencies. This plan of correction is being submitted good faith by the facility because it is required | in | 05/18/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|--|--------------------------------|---|--------|---|---------------|----|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | I DING | 00 | COMPLETED | |
| | | 155672 | B. WIN | | | 04/18/2011 | |
| | | <u> </u> | P. 1121 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIEI | R | | 1 | CHICAGO TRAIL | | |
| | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | · · | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | ϽN |
| TAG | † | R LSC IDENTIFYING INFORMATION) | + | TAG | , | DATE | |
| | | eviewed for physician | | | law. The facility reserves the right to | , | |
| | notification in a sample of 16. (Resident # 85, #48). Findings include: | | | | contest the statement of | | |
| | | | | | deficiencies. | | |
| | | | | | F157 | | |
| | | | | | | | |
| | | | | | NO RESIDENTS WERE | , | |
| | Resident # 85's | closed record was | | | ADVERSLEY AFFECTED BY THIS ALLEGED | | |
| | reviewed on 4/1 | 4/11 at 8:00 a.m. The | | | DEFICIENCY. | | |
| | resident's record | indicated diagnoses of, | | | DEFICIENCY. | | |
| | | o; Alzheimer's disease, | | | It is the policy and practice of | | |
| | osteoporosis, glaucoma, congestive heart | | | | Hamilton Grove to notify the | | |
| | 1 - | _ | | | attending physician of | | |
| | failure, cerebral vascular accident, transient ischemic attacks, and seizures. | | | | any significant resident status | | |
| | l'ansient ischem | ic attacks, and scizures. | | | changes in a timely manner. | | |
| | Nurses' notes re | viewed for the resident's | | | For resident number 48 and 85 | | |
| | | | | | sufficient time has elapsed which | _{zh} | |
| | 1 | on, dated February 17, | | | precludes the | | |
| | 2011, indicated | • | | | immediate correction of this all | eged | |
| | 1 ' ' ' | every) meal normally, | | | deficiency, i.e. physician | | |
| | | eater than) 40% of meals. | | | notification. | | |
| | Res is full assist | with meals" | | | All residents that requ | ,ira | |
| | | | | | physician notification due to cr | | |
| | 1 | ated March 3, 10, 17, 24, | | | changes in their | | |
| | and 31st, 2011, | indicated the resident ate | | | health status and residents recei | ving | |
| | a pureed diet and | d fed by staff. | | | insulin have the potential of bei | ng | |
| | | | | | affected by this | | |
| | The resident's re | cord indicated at 11: 45 | | | finding. All nurses will be | , | |
| | a.m. on 4/1/11, s | she experienced a ground | | | re-inserviced on the guidelines | and | |
| | 1 | er wheelchair. The nurses' | | | proper assessment procedures for physician notific | eation | |
| | notes indicated of | on 4/4/11 "Res (Resident) | | | of change in condition by May | | |
| | | o checks wnl (within | | | 2011. | | |
| | | lert to self, not taking | | | | | |
| | fluids or food well, no hx (history), alarms | | | | This corrected action plan will | | |
| | 1 | esident's record lacked | | | ensure that a resident undergoin | ıg | |
| | 1 - | | | | significant changes | _ | |
| | i documentation t | o indicate the physician or | - 1 | | in their health status will receive | ا ت ا | |

Y4C611

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|--|---|---------|--------------|---|-------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155672 | A. BUII | LDING | 00 | 04/18/2011 |
| | | 155672 | B. WIN | | | 04/16/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | |
| наміі та | ON GROVE | | | 1 | CHICAGO TRAIL ARLISLE, IN46552 | |
| | | TATEMENT OF DEPLOYING THE | | | 7 (**CIOEE, 114-0002 | (11) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE |
| | | been notified of the | | | timely physician notification. | |
| | | in food and fluid | | | | |
| | consumption. | | | | All residents receiving insulin h | nad |
| | Consumption. | | | | physician orders clarified for | |
| | Nurses' note_date | ed 4/7/11 at 11:00 p.m., | | | parameters and notification requirements. | |
| | · · | ly: Pt (patient) resting | | | and notification requirements. | |
| | | ot eating this shiftno | | | The Director of Nursing/Design | nee |
| | 1 1 | reathing very shallow" | | | will audit all residents receiving | g |
| | * | acked documentation to | | | insulin daily for the first month then monthl | |
| | | | | | thereafter. In addition, The Dir | · 1 |
| | indicate the physician or dietitian had been notified of the above comments. | | | | of Nursing/ | |
| | | | | | Designee will audit the daily | |
| | Nurses' note date | ed 4/8/11 at 6:00 a.m., | | | communication report-daily for | |
| | · · | dent had a decreased | | | next 30 days, then monthly ther | |
| | | oted. The note failed to | | | to ensure that physician's are no in a timely manner when a resion | |
| | | ician was notified of the | | | undergoes a critical or serious | lent |
| | 1 | wing until 1:00 p.m. the | | | condition change. | |
| | same day. | wing until 1.00 p.m. the | | | | |
| | sume day. | | | | The Administrator/Designee wi review these findings weekly ar | |
| | Nurses' note date | ed 4/9/11 at 2:00 p.m,. | | | submit his/her | iu |
| | l ' | dent took sips of juice | | | observations to the Quality | |
| | | er of applesauce. The | | | Assurance Committee for further | er |
| | | gns were documented at; | | | review and | |
| | 1 | Biox 90 (measurement | | | recommendations. | |
| | | blood with normal range | | | This will be done monthly for the | he |
| | , , , | se 86, blood pressure | | | first ninety (90) days then quart | |
| | 128/70. | oo, oloog plebbale | | | thereafter or until | |
| | 120//0. | | | | a 95% compliance threshold is | met. |
| | At 11:30 n m or | n 4/9/11 the nurse's note | | | By what date the systemic chan | ges |
| | | emperature) 103.0, P | | | will be completed is: May 18, | |
| | ` | espirations) 50, B/P | | | | |
| | | 86/37. Mottling present | | | | |
| | to bil (bilateral) l | • • | | | | |
| | ` ′ | sident not taking any | | | | |
| | | | | | | |

000427

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED | | | | |
|---|--|---|--|--------------|--|----------|--------------------|
| 1111212111 | or condition | 155672 | A. BUII B. WIN | | | 04/18/20 | |
| NAME OF I | PROVIDER OR SUPPLIER | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | | | | 1 | CHICAGO TRAIL | | |
| | ON GROVE | | | | ARLISLE, IN46552 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` · | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | food/fluid po (by | mouth). Resident does | | | | | |
| | | oes not respond to verbal | | | | | |
| | | no reaction to physical | | | | | |
| | | Resident's record failed | | | | | |
| | • | nysician had been notified needs. No order was | | | | | |
| | | obtained for the 103 | | | | | |
| | temperature the r | | | | | | |
| | experiencing. | | | | | | |
| | | | | | | | |
| | During an interview with the Director of | | | | | | |
| | _ | 11 at 2:15 p.m. she | | | | | |
| | | sident declined rapidly | | | | | |
| | | e further indicated the | | | | | |
| | | have been notified of the | | | | | |
| | high temperature | n intervention could have | | | | | |
| | been obtained for | | | | | | |
| | | Comfort. | | | | | |
| | 2. The clinical | l record of Resident # | | | | | |
| | 48 reviewed or | n 4/11/11 at 2:50 | | | | | |
| | P.M., indicated | d diagnoses of, but | | | | | |
| | ŕ | diabetes mellitus, | | | | | |
| | cerebrovascula | · · · · · · · · · · · · · · · · · · · | | | | | |
| | hypertension, | | | | | | |
| | vascular diseas | • • | | | | | |
| | , assaiai aissai | J - . | | | | | |
| | A Physician O | rder, dated 9/15/09, | | | | | |
| | _ | cu Check (blood | | | | | |
| | · · | ore meals and at | | | | | |
| | - | M (diabetes mellitus). | | | | | |
| | | ivi (diaucies ilicilitus). | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MU A. BUIL B. WING | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|--|--|---------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIIN | STREET A | DDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| TAG | A second Phys 12/3/10, indica (injection) 100 inject 8 units severy morning Review of the 4/30/11 MAR Administration Resident # 48' Check was 86 (medication according to the second part of the second par | sician Order, dated ated, "Novolog inj b/ml (milliliters), ub q (subcutaneous) for DM. 4/1/11 through (Medication a Record) indicated, s 5:00 A.M. Accu | | TAG | DEFICIENCY) | | DATE |
| | "glucose 86, initials)" Resident # 48' 3/25/11, indica (Resident # 48 Mellitus Type Administer me prescribed" Review of the lacked docume assessment and | IIInterventions: 1. edications as clinical record, entation of nursing | | | | | |

000427

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NUM | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV 00 COMPLETED | | | | | |
|---|-----------------------------------|---|---|-------------|--------------------|--------------------------------------|-----------------------|------------|
| AND PLAN | OF CORRECTION | 155672 | A. BUI | LDING | 00 | | 04/18/2 | |
| | | 100072 | B. WIN | | | | U -1 /10/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | DDRESS, CITY, STAT | | | |
| HAMII TO | ON GROVE | | | 1 | ARLISLE, IN4655 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE | AN OF CORRECTION ACTION SHOULD BE | _ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | | O TO THE APPROPRIAT CIENCY) | E | DATE |
| | | | i | ĺ | | | | |
| | Interview on 4 | -/12/11 at 4:15 P.M., | | | | | | |
| LPN # 1 indicated, the record | | | | | | | | |
| | | entation indicating | | | | | | |
| | | d the hold of the | | | | | | |
| | morning insuli | | | | | | | |
| | morning mount | in dusc. | | | | | | |
| | The DON (Dir | rector of Nursing) on | | | | | | |
| | ` | P.M., indicated | | | | | | |
| | | the Resident ate | | | | | | |
| | | | | | | | | |
| | _ | linner the night | | | | | | |
| | before so she o | | | | | | | |
| | _ | iving the insulin | | | | | | |
| | | sident has periods of | | | | | | |
| | unresponsiven | ess however she did | | | | | | |
| | not notify the j | physician of the | | | | | | |
| | holding of Res | sident # 48's insulin. | | | | | | |
| | | | | | | | | |
| | On 4/13/11 at | 1:00 P.M., the DON | | | | | | |
| | indicated the n | nurse should notify | | | | | | |
| | the physician i | if a resident does not | | | | | | |
| | get a medication | | | | | | | |
| | 8:: :: :::: | | | | | | | |
| | The DON prov | vided a fax cover | | | | | | |
| | • | 11 at 3:15 P.M., dated | | | | | | |
| | | 11-7, indicated, | | | | | | |
| | · · | (Name), A.M. | | | | | | |
| | | * | | | | | | |
| | glucose 86, insulin held D/T (due | | | | | | | |
| | to) slow to aro | ouse not sure if will | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Versio | ons Obsolete Event ID: | Y4C611 | Facility II | D: 000427 | If continuation sh | neet Pa | ge 8 of 72 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MUI A. BUILD B. WING | | OO | (X3) DATE S COMPL 04/18/20 | ETED | |
|--|--|---|-----|--------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | | 31869 C | DDRESS, CITY, STATE, ZIP CODE HICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | eat A.M. meal, also refused to get up per usual", however the fax cover sheet lacked the verification stamp indicating it was faxed. A facility policy titled "Guidelines for Physician Notification for Change in Condition", non dated, indicated, "Medical care problems are communicated to the attending physician in a timely, concise, and thorough mannerThe nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate assessment" 3.1-5(a)(2) | | | | | | |
| F0168 SS=C | from agencies act be afforded the op agencies. Based on intervious facility failed to access to informating agencies for clien | right to receive information ing as client advocates, and portunity to contact these ews and observation, the ensure residents had ation regarding contacting int advocates for 80 of 80 accility who may wish to | F01 | 68 | F168 NO RESIDENTS WERE ADVERSLEY AFFECTED BY | | 05/18/2011 |

| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | (X3) DATE SURVEY | |
|-----------|----------------------|------------------------------|---|---------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED | |
| | | 155672 | B. WIN | | | 04/18/2011 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | CHICAGO TRAIL | | |
| LIAMILTO | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| HAIVIILIC | JN GROVE | | | I NEW C | ARLISLE, IN40002 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | |
| | contact an advoc | ate. | | | THIS ALLEGED | İ | |
| | | | | | DEFICIENCY. | | |
| | Findings include | | | | | | |
| | Tillulings illetude | - | | | It is the policy of Hamilton Gro | ve to | |
| | | | | | provide each resident of the fac | ility | |
| | | t group meeting on | | | appropriate advocacy agent | | |
| | 4/12/11 at 3:00 p | .m., 11 of the 12 alert | | | information so they may contac | t | |
| | and oriented resid | dents indicated they were | | | these agencies any | | |
| | | posted information | | | time they choose. | | |
| | _ | ble to call a resident | | | | a. | |
| | | | | | The framed forms referenced in | | |
| | _ | needed to. The residents | | | alleged deficiency, were moved | | |
| | | ere in the facility they | | | down so | 7.1 | |
| | could find this in | formation. One resident | | | that they are now visually acces | | |
| | in the meeting w | ho requested to remain | | | to anyone sitting in a wheelchain. The font | r. | |
| | _ | ated she saw the form on | | | size of the first document is a co | ony of | |
| | - | orint was so small she | | | an official Indiana State Depart | | |
| | _ | office was so small sile | | | of | ment | |
| | couldn't read it. | | | | Health form with a complaint | | |
| | | | | | telephone number to call clearly | , | |
| | During a tour of | the facility on 4/13/11 at | | | legible from | | |
| | 9:30 a.m. an obse | ervation was made of a | | | distances beyond five (5) feet. | The | |
| | framed form con | taining information | | | font size is in excess of 28 K. | | |
| | | ting the Ombudsman (a | | | | | |
| | | _ | | | The second framed form with | | |
| | resident advocate | <i>'</i> | | | Fourteen (14) Federal and State | | |
| | | observed hanging 5 feet | | | agencies, including | | |
| | from the ground | and located in the hall | | | the State and Area Ombudsman | . | |
| | near the entrance | of the facility. The print | | | numbers to call or fax IS IN 13 | к | |
| | | very small and had to be | | | LARGE CAPS, | | |
| | | he information would not | | | BOLD FONT TIMES, ROMA | N | |
| | be available to an | | | | and 13 K small caps, bold font | , | |
| | | iy iesiuciii iii a | | | Times, Roman. | | |
| | wheelchair. | | | | Both signs are now posted | | |
| | | | | | approximately one foot or less a | above | |
| | 3.1-3(b)(2) | | | | the hand rail at the | _ | |
| | | | | | main –non-licensed section of t | he | |
| | | | | | building. | | |
| | | | | | | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 04/18/2011 | |
|---|---------------------|---|---------------------|---|--|
| | ROVIDER OR SUPPLIER | | STREET A 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | |
| | | | | All nursing units contained exerplicas of the same postings at a height clearly legible by all 80 reside noted in this citation who wis access them before the inspectors arrived of 11, 2011 and throughout the sprocess. The Administrator/ Designee assure continued compliance visually noting the presence and location of the Ombudsman (a resident advoctelephone number at least weekly for four (4) we then quarterly thereafter to the Quality Assurance Committee. This was completed on Tuesd April 22, 2011. | ents hed to on April urvey will by ne cate) |

000427

| İ | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | SURVEY | |
|---------------|--|---|--|---------|--|---------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| HAMILTO | PROVIDER OR SUPPLIER | | | 31869 C | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | • | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) |
| PREFIX | · · | CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION) | | PREFIX | | | COMPLETION |
| F0279 SS=D | A facility must use assessment to de resident's compre The facility must de care plan for each measurable object a resident's medic psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as the care plan must are not provided exercise of rights right to refuse treat Based on observing record review, the a care plan was used interventions to play falling out of her soldent with a standard resident with a standard resident # 55). Affected 2 of 16 to care plans in a safe Findings included 1. Resident # 85' reviewed on 4/14 resident's record. | velop, review and revise the hensive plan of care. levelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and dis that are identified in the seessment. Ist describe the services that die to attain or maintain the practicable physical, associal well-being as 83.25; and any services that he required under §483.25 and due to the resident's under §483.10, including the atment under §483.10(b)(4). The ations, interviews and the facility failed to ensure updated with prevent a resident from the wheelchair (Resident # 10) update a care plan for a stage 3 pressure ulcer. This deficient practice residents reviewed with temple of 16. | F0 | 279 | F279 It is the policy of Hamilton Grodevelop a comprehensive residencare plan to ensure continuity of care These individualized care plans based on timely resident assessments and updated at least annually, quart and when there is a significant change of condition. NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. | ent e. s are d erly | 05/18/2011 |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155672 04/18/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 31869 CHICAGO TRAIL HAMILTON GROVE NEW CARLISLE, IN46552 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE For resident number 85 sufficient osteoporosis, glaucoma, congestive heart time has elapsed which precludes the failure, cerebral vascular accident, immediate correction of this alleged transient ischemic attacks, and seizures. deficiency. The Resident's quarterly MDS (minimum For resident number 55, the resident' s care plan was immediately updated data set) assessment dated 1/5/11 indicated the Resident's cognitive status include an intervention and goal to was severely impaired. She required total move the resident's cushion between assistance with 2 staff for transfers. She required total assistance for dressing, wheelchair and recliner or when transferred from one sitting surface eating, and bathing. another Nurses' note dated 4/1/11, 11:45 a.m. indicated "Resident leaning forward in All residents specialty seating w/c (wheelchair), alarm sounded, fell cushions have the potential of being affected by forward out of w/c before staff could this finding. reach her...." The corrected action plan will ensure Nurses notes dated 3/3/11 (no time) that all residents receiving specialty indicated n/o (nursing order) for OT wheelchair cushions will have their care plans updated to include an (occupational therapy) for w/c intervention positioning...." to move their specialty seat cushion from one sitting surface to another to Nurses note dated 3/5/11 (no time) ensure continuity of care services. indicated "Res (Resident) is leaning in Nursing staff were re-inserviced on w/c, repositioned by staff several time up-dating care plans which includes (sic) therapy order for OT already specific information regarding seat received." The Resident's record lacked cushion transfers when a resident documentation to indicate what was put in place while the resident was in her from one sitting surface to another, e.g., from wheelchair to resident's wheelchair prior to a therapy evaluation. recliner or from wheelchair to dining room chair Nurses' note dated 3/7/11, 10 (not indicated if a.m. or p.m.) Res leans to (R)

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|------------------------------|----------------------------|--------------------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155672 | B. WIN | | - | 04/18/2 | 011 |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | CHICAGO TRAIL | | |
| HAMILTO | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | , | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | `` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | DATE |
| 0 | | time OT has order to | | | | | DITE |
| | eval." | inic O1 has order to | | | Director of Nursing/Designee v | vill | |
| | evai. | | | | audit all care plans for residents | | |
| | | | | | receiving | | |
| | | cupational Therapy note | | | specialty seating cushions for | | |
| | | icated "Pt (patient) | | | next 30 days than 10 percent m | | |
| | with increased ri | | | | thereafter to ensure care plan go and interventions are appropria | | |
| | | leaning and forward | | | current. | ic and | |
| | leaningclinical | | | | | | |
| | | essments- pt presented in | | | The Administrator/Designee wi | 11 | |
| | an 18 inch wide | w/c with elevated leg | | | review these findings weekly a | nd | |
| | rests, no cushion | present. Pt LEs (lower | | | submit his/her | | |
| | extremities) were | e dropping off leg rests | | | observations to the Quality Assurance Committee for furth | | |
| | medially which, | when this happened, | | | review and | e1 | |
| | forward flexed p | t at hips pt requires OT | | | recommendations. This will be | done | |
| | services to positi | on her in w/c due to risk | | | monthly for the first ninety (90) | | |
| | of falls from late | ral and forward leaning | | then quarterly thereafter or until a | | | |
| | which is not imp | roving with nursing | | | 95% compliance threshold is m | et. | |
| | interventions" | _ | | | B 1 (1) (1) (1) | | |
| | | | | | By what date the systemic chan will be completed: May 18, 20 | - | |
| | Occupational Th | erapy note dated 4/5/11 | | | will be completed. Way 16, 20 | 11 | |
| | after the resident | | | | | | |
| | | cated "Final summary: | | | | | |
| | | gains: OT recommended | | | | | |
| | w/c tipped back of | | | | | | |
| | | | | | | | |
| | | w profile air cushion | | | | | |
| | | thrust capabilities to | | | | | |
| | 1 ^ | tingOn date of d/c | | | | | |
| | | ad leaned forward and fell | | | | | |
| | | eported w/c breaks (sic) | | | | | |
| | were locked. Educated nursing to not leave breaks (sic) locked when pt is unattended" | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Resident # 85's p | olan of care dated 8/20/10 | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | A. BUILD | | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 | ETED | | |
|---|---|---|---|----------------|---------------------------------|------|----------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| | SUMMARY S (EACH DEFICIEN REGULATORY OR indicated "Proble at risk for falls r/ safety awareness Alzheimer's dem (cerebral vascula hx (history) of fa The Resident's pl address her leani wheelchair or an place to prevent recommendation Therapy for a w/ or the low profile antithrust capabil in the Resident's Resident's record the Resident had not. During an intervi Nursing on 4/15/ lack of interventi resident from lea | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ems: (Resident name) is t (related to) impaired d/t her dx (diagnosis) of entia/ late affect CVA r accident) and she has a lls in the past" an of care did not ng forward in her y interventions put in | PF | 31869 C | CHICAGO TRAIL | | (X5) COMPLETION DATE | |
| | indicated the hou completed after t from the wheelch the interventions | The documentation rly checks were he resident had fallen nair. She further indicated Occupational Therapy t been put into place. | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 00 | | | (X3) DATE S | | |
|--|---|--|--------|---------------|--|-----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155672 | A. BUI | LDING | 00 | COMPL: 04/18/20 | |
| | | 155672 | B. WIN | | | 04/16/20 | JII |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| LIAMIITO | ON GROVE | | | 1 | CHICAGO TRAIL ARLISLE, IN46552 | | |
| | | | | | ARLISLE, IN40002 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | `` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| IAG | | 's clinical record was | EC | 279 | | | 05/18/2011 |
| | | /11 at 3:20 P.M. and | 10 | 1219 | | | 03/16/2011 |
| | | | | | F279 | | |
| | 1 | ses of, but not limited to: | | | T. 1 1 0H 7H 7H 6 | | |
| | osteoarthritis, ost | eoporosis, and | | | It is the policy of Hamilton Gro develop a comprehensive reside | | |
| | hypertension. | | | | care | ent | |
| | Damin a initial tan | on af the Fact Huit on | | | plan to ensure continuity of care | e. | |
| | ~ | or of the East Unit on | | | These individualized care plans | are | |
| | 4/11/11 at 10:25 | | | | based on | . | |
| | | LPN #1, Resident # 55 | | | timely resident assessments and updated at least annually, quart | | |
| | | ting slouched in the | | | and when | erry | |
| | recliner in her room. LPN # 1 identified her as confused, ambulatory with one | | | | there is a significant change of | | |
| | | | | | condition. | | |
| | 1 ^ | n an acquired open area | | | | | |
| | to her coccyx. | | | | NO RESIDENTS WERE | 7 | |
| | I DAT // 1 ' 1' | 1 | | | ADVERSLEY AFFECTED BY THIS ALLEGED | | |
| | | d in an interview, at the | | | DEFICIENCY. | | |
| | | e mentioned observation, | | | | | |
| | _ | the coccyx was a stage III | | | For resident number 85 sufficie | | |
| | ` | ssue loss. Subcutaneous | | | time has elapsed which preclud | | |
| | 1 | e but bone, tendon or | | | immediate correction of this all deficiency. | egea | |
| | 1 ^ | oosed). She further | | | deficiency. | | |
| | | nt #55 had a low air loss | | | For resident number 55, the res | ident' | |
| | | alized mattress that | | | s care plan was immediately up | dated | |
| | 1 | tributes the fluctuation of | | | to | 14. | |
| | | nen queried if Resident | | | include an intervention and goa move the resident's cushion bet | | |
| | _ | lized seat cushion to aid | | | the | . ** CC11 | |
| | 1 | the pressure ulcer, LPN | | | wheelchair and recliner or when | n | |
| | | resident did have the | | | transferred from one sitting sur | face | |
| | _ | on and was seated on it. | | | to | | |
| | | d not be observed under | | | another. | | |
| | | e time because of the way | | | All residents specialty seating | | |
| | the resident was | slouched in the chair. | | | cushions have the potential of b | eing | |
| | | | | | affected by | - | |
| | A Nurse's Note, o | dated 3/26/11 at 3:50 | | | this finding. | | |

000427

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|--|----------------------------|--------------|--|--------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | DINC | 00 | COMPLETED | |
| | | 155672 | B. WIN | | | 04/18/2011 | |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | CHICAGO TRAIL | | |
| HAMII TO | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| | | | | L | , ii (2.022, ii (10002 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION | |
| TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | DATE | |
| mo | | · | - | I/IG | | DATE | |
| | * | "During care CNA | | | The corrected action plan will e | ensure | |
| | · | g Assistant) called this | | | that all residents receiving spec | | |
| | | ents bathroom. Open area | | | wheelchair cushions will have t | | |
| | | occyx 1.5 x 0.5 x 0.3, | | | care plans updated to include a | n | |
| | • | ed dressing) applied, | | | intervention | | |
| | M.D. (Medical D | Ooctor) notified, POA | | | to move their specialty seat cus | | |
| | (Power of Attorn | ey) notified." | | | from one sitting surface to anot ensure continuity of care service | | |
| | | | | | ensure continuity of care service | | |
| | During observati | on of wound care to | | | Nursing staff were re-inserviced | i on | |
| | resident # 55's st | age III pressure ulcer on | | | up-dating care plans which incl | | |
| | | .M., LPN #1 asked | | | specific information regarding s | | |
| | | stand up from her recliner | | | cushion transfers when a reside | nt | |
| | | the wound treatment. It | | | moves | . | |
| | - | that time, the pressure | | | from one sitting surface to anot | | |
| | | shion was not in her | | | e.g., from wheelchair to resident recliner or | .1.5 | |
| | _ | er in her wheel chair | | | from wheelchair to dining room | n chair | |
| | · · | near her bed. CNA #20 | | | etc. | | |
| | | | | | | | |
| | | g LPN #1 indicated she | | | Director of Nursing/Designee w | | |
| | _ | transfer Resident #55, | | | audit all care plans for residents | i | |
| | · | forgot to put her seat | | | receiving | | |
| | | cliner before transferring | | | specialty seating cushions for next 30 days than 10 percent me | | |
| | her into it. | | | | thereafter to ensure care plan go | - 1 | |
| | | | | | and interventions are appropriate | | |
| | Resident #55 was | s observed on 4/12/11 at | | | current. | | |
| | 4:55 P.M. sitting | in her wheel chair in the | | | | | |
| | East Unit dining | room. She did not have | | | The Administrator/Designee wi | | |
| | her seat cushion | in the wheel chair. The | | | review these findings weekly ar | nd | |
| | seat cushion was | observed in the recliner | | | submit his/her observations to the Quality | | |
| | in her room at 4:57 P.M. At 5:00 P.M., the Director of Nursing confirmed Resident #55 was without her seat cushion while up in her wheel chair. | | | | Assurance Committee for further | er | |
| | | | | | review and | | |
| | | | | | recommendations. This will be | done | |
| | | | | | monthly for the first ninety (90) | | |
| | | | | | then quarterly thereafter or unti | | |
| | During intomi | with the Director of | | | 95% compliance threshold is m | et. | |
| | During interview | with the Director of | 1 | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 04/18/2 | LETED | |
|---|--|--|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | 31869 C | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | 3 | (X5) COMPLETION DATE |
| | indicated it was l | 11 at 3:10 P.M., she her responsibility to ent's Care Plan, but she | | By what date the systemic ch will be completed: May 18 , | - | |
| | "Problems: (Resipressure ulcer de to) impaired bedProvide skin tx needed/ordered and position ever (Resident #55) si alleviate unwante prominence's3/ Mattress to bed (topical wound to (dressing) to low Resident # 55's or reviewed, but the | dent #55) is at risk for velopment R/T (related mobilityApproaches: 's (treatments) as red Clock Program (turn ty two hours). Turn de to side when in bed to ed pressure to bony (29/11: Low Loss Air (4/1/11: Calcium Alginate reatment) with drsg er coccyx wound" ther Care Plans were by also lacked f a pressure relieving seat | | | | |
| | (resident Care Pl indicated, "Purpo individualized re | sident care plan, with om nursing and other | | | | |
| | evaluating qualit accomplishment. for nursing assig | y of care and goal To provide guidelines nmentsProcedure:10. may be prioritized if | | | | |

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|--|---------------------|---------------------------------------|---------|---------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| | | | D. W.1. | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 31869 (| CHICAGO TRAIL | | |
| | N GROVE | | | | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | - | he person responsible for | | | | | |
| | each procedure of | or activity will be | | | | | |
| | identified by init | ials in the appropriate | | | | | |
| | column" | | | | | | |
| | | | | | | | |
| | 3.1-35(a) | | | | | | |
| | 3.1-35(b)(1) | | | | | | |
| | | | | | | I | |
| | | | | | | I | |
| | | | | | | | |
| | | | | | | | |
| F0282 | The services provi | ded or arranged by the | ł | | | ŀ | |
| SS=D | | ovided by qualified persons | | | | | |
| 00-0 | | n each resident's written | | | | | |
| | plan of care. | | | | | | |
| | Based on observa | ation, interview, and | F0 | 282 | | | 05/18/2011 |
| | record review, th | e facility failed to ensure | | | F282 | | |
| | physician orders | were followed for | | | NO RESIDENTS WERE | | |
| | | nistration for 1 of 16 | | | ADVERSLEY AFFECTED BY | , | |
| | | ent # 32) reviewed for | | | THIS ALLEGED | | |
| | ` | , , , , , , , , , , , , , , , , , , , | | | DEFICIENCY | | |
| | | ed to follow physician | | | | l | |
| , l | | transfer assistance for 1 | | | It is the policy of Hamilton Gro | ve to | |
| | | viewed for transfers | | | ensure services are provided or | | |
| | ` | d failed to follow | | | arranged utilizing | | |
| | physician orders | for pressure ulcer care | | | a qualified person in accordance | | |
| | for 1 of 3 residen | nts (resident #51) | | | each resident's written plan of c | are. | |
| | reviewed with pr | essure ulcers in a sample | | | 1. For resident 32 sufficient tim | a haa | |
| , l | of 16. | • | | | elapsed to preclude immediate | e nas | |
| | | | | | correction of this | | |
| | Findings include | - | | | alleged deficiency as it relate | s to: | |
| | i mamas merade | • | | | (a) Metformin, (b) Misoprosto | | |
| | 1 A Dagidant # | 51's clinical record was | | | Fortical, | | |
| | | | | | (d) Tizainidine | | |
| | | 3/11 at 9:20 A.M. and | | | | l | |
| | indicated diagnos | ses of, but not limited to: | | | 2. For resident number 51 resid | | |
| | | | | | transfer status was clarified to r | eflect | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|--|---|------------------------------|--------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | • | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | FRO VIDER OR SUFFLIER | | | 31869 0 | CHICAGO TRAIL | | |
| | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ГЕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | | nentia, stage III pressure | | | a mechanical | | |
| | ulcer, and a fall | with pelvic fracture times | | | lift and care plan updated. | | |
| | two. | | | | 3. In addition, a sock was remo | ved | |
| | | | | | from resident's foot and a new | | |
| | During initial to | ur of the East Unit on | | | clarified that | | |
| | 4/11/11 at 10:25 | A.M. while accompanied | | | only toes may be covered. | | |
| | | indicated Resident #51 | | | | | |
| | 1 * | olation with MRSA | | | 1A. All residents receiving | | |
| | | stant Staphylococcus | | | mediation have the potential of | being | |
| | | e III (Full thickness tissue | | | affected by this alleged deficiency. | | |
| | | | | | aneged deficiency. | | |
| | loss. Subcutaneous fat may be visible but | | | | Facility's pharmacy will audit a | 11 | |
| | bone, tendon or muscle is not exposed) | | | | resident medications to ensure | | |
| | l ^ | the left heel. She further | | | availability of | | |
| | | ent #51 was a two person | | | medications. | | |
| | | rs and used a mechanical | | | | | |
| | lift for the transf | er. | | | In addition, a letter was reissued | | |
| | | | | | resident and families who utiliz outside | e | |
| | Resident #51's a | nnual MDS (Minimum | | | pharmacy services, reminding t | hem | |
| | Data Set) Assess | sment, dated 2/09/11, | | | that the Hamilton reserves the r | | |
| | indicated she wa | s severely cognitively | | | to order a | | |
| | impaired and she | e needed extensive assist | | | resident's medication from the | | |
| | of two staff for t | ransfers. | | | facility's pharmacy when outsic | le | |
| | | | | | pharmacy services | | |
| | The Care Area A | Assessment (CAA) | | | fail to deliver the resident's prescription drugs in a timely | | |
| | | 2/09/11, indicated, "11. | | | manner. This letter is | | |
| | 1 | ered for (Resident #51) | | | provided on an admission and a | t | |
| | | ty awareness is impaired | | | least annually. | | |
| | | - | | | | | |
| | ` ′ | her dx (diagnosis) of | | | Furthermore, a new expanded | | |
| | | nentia and she has a dx. of | | | Emergency Drug Kit (EDK) wa | ıs | |
| | | ncing her at risk for injury | | | ordered and is | 0 | |
| | | ransfer (Resident #51) | | | expected to arrive before May 1 2011. The New EDK will contain | | |
| | | e asst (assistance) of 2 | | | supply of the | 4111 U | |
| | using the E-Z St | and (mechanical lift)" | | | four medications listed in this a | lleged | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--------------------------------|-------------------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIIII | DDIC | 00 | COMPL | LETED |
| | | 155672 | A. BUII B. WIN | | | 04/18/2 | 011 |
| | | <u> </u> | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | 1 | CHICAGO TRAIL | | |
| нами та | ON GROVE | | | | ARLISLE, IN46552 | | |
| | | | | L | AILIOLL, IIV+0002 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | ŧ | R LSC IDENTIFYING INFORMATION) | + | TAG | · · · · · · · · · · · · · · · · · · · | | DATE |
| | • | tiated 2/24/11, indicated, | | | deficiency. | | |
| | ` | dent #51) is at risk for | | | The corrected action plan will | encure | |
| | serious injury R. | T falls D/T (due to) poor | | | The corrected action plan will ensure that all residents' | | |
| | safety awareness | sApproaches: Transfer | | | medications/biologicals are | | |
| | (resident #51) w | ith the use of the E-Z | | | available to administer at all ti | mes as | |
| | Stand and assist | of 2 staff, positioning her | | | prescribed by their physician. | | |
| | extremities for s | - | | | | | |
| | | u200y | | | 1B. All residents with physicial | an | |
| | During observat | ion on 4/13/11 at 12:02 | | | orders for mechanical lift for | | |
| | _ | \$ 51's room-mate was | | | transfers have the | 1 | |
| | · · | | | | potential of being adverse affected by this finding. | ely | |
| | _ | in the East Unit dining | | | affected by this finding. | | |
| | | 0 was observed entering | | | All residents with physician or | ders | |
| | | oom and greeted her. | | | for the use of mechanical lifts | | |
| | | as lying in her bed. CNA | | | transfers were | | |
| | #20 then remove | ed her gait belt as she | | | reviewed and care plans update | | |
| | slowly closed th | e door to the room. | | | reflect appropriate physician of | rders. | |
| | Several minutes | lapsed when CNA #20 | | | A11 N | | |
| | was observed ex | titing Resident #51's room | | | All Nursing staff were re-in se on following physician orders | rviced | |
| | with her now sea | ated in her wheel chair. | | | relative to | | |
| | No other staff ex | kited the room with them | | | mechanical lifts for transfers. | | |
| | | ng further, no staff was | | | | | |
| | _ | room or bathroom. CNA | | | The corrected action plan will | ensure | |
| | | a mechanical lift into | | | that staff will follow physician | orders | |
| | | oom to use with the | | | for | | |
| | | oom to use with the | | | mechanical transfers. | | |
| | transfer. | | | | 1C. For resident 51 the socks | wara | |
| | | | | | immediately removed by nursi | | |
| | | ted in an interview on | | | staff. | ···b | |
| | 4/13/11 at 12:45 P.M., she was sorry she did not get another staff person to help her with the transfer of Resident #51 from her bed to the wheel chair. "I usually do. I just didn't do it today." | | | | | | |
| | | | | | All Residents with specia | 1 | |
| | | | | | physician orders for pressure u | lcer | |
| | | | | | care have a | | |
| | | | | | potential for being affecte | d by | |
| |] | | | | this alleged deficiency. | | |
| | 1. B. During ini | tial tour of the East Unit | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|--|--|----------------------------|---|---|------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLI | ETED |
| | | 155672 | B. WIN | | | 04/18/20 | 011 |
| | | | В. ТП | | ADDRESS, CITY, STATE, ZIP CODE | l | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | CHICAGO TRAIL | | |
| HAMILTO | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| | | TATEL OF DEFICIENCIES | _ | | | | 07.5 |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT | re | COMPLETION DATE |
| IAU | | · | <u> </u> | IAU | All Physician orders were | - | DATE |
| | on 4/11/11 at 10: | | | | reviewed for each resident recei | iving | |
| | | LPN #1, she indicated | | | pressure ulcer care | IVIIIg | |
| | Resident #51 was in contact isolation with | | | | to ensure orders are being | | |
| | MRSA (methicil) | | | | followed. | | |
| | Staphylococcus a | aureus) to an acquired | | | | | |
| | stage III pressure | ulcer on the left heel. | | | Director of Nursing/Design | nee | |
| | | | | | will review residents receiving | | |
| | Review of a Care | e Plan, initiated 2/24/11, | | | pressure ulcer care | , | |
| | | em: (Resident #51) has 2 | | | daily to ensure physician o | | |
| | • | sure ulcers, one on each | | | are being followed. This will be done for 30 (thirty) | | |
| | heel. Her bed me | · | | | days then monthly thereaft | er | |
| | | • | | | days then monthly thereare | | |
| | | paches:Do not apply | | | Nursing and Therapy staff will | be | |
| | | et per MD (Medical | | | re-inserviced on following spec | | |
| | , and the second | nd float heels when in | | | physician orders | | |
| | bed as NSG (Nu | rsing) measure" | | | for residents receiving pressure | ulcer | |
| | | | | | care. | | |
| | A Nurse's Note, | dated 12/21/10 at 10 | | | | | |
| | A.M., indicated, | "bilat. (bilateral) heels | | | The corrected action plan will e | | |
| | | s air mattress, medboots | | | that all special physician orders residents | 101 | |
| | at all times. No | | | | receiving pressure ulcer care are | e | |
| | at all tilles. To | SHOO, BOOKS | | | appropriately followed. | ` | |
| | Regident #511a C | are Area Assessment | | | , | | |
| | | | | | The Administrator/Designo | | |
| | | v indicated, "(Resident | | | will review these findings week | ly | |
| | , , , , , , , , , , , , , , , , , , , | boots to her feet at all | | | and submit his/her | | |
| | • | are floated when in bed | | | observations to the Quality | | |
| | | orders for no shoes/socks | | | Assurance Committee for further review and | er | |
| | to her feet" | | | | recommendations. | | |
| | | | | | recommendations. | | |
| | During observati | on of wound care on | | | This will be done monthly | for | |
| | 4/13/11 at 11:05 A.M. while accompanied by Physical Therapist (PT) #21, Resident | | | | the first ninety (90) days then | | |
| | | | | | quarterly thereafter or | | |
| | | d lying in bed. She had | | | until a 95% compliance | | |
| | | on socks pulled up over | | | threshold is met. | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | both feet. Her ba | andaged left heel was | | | | | |

000427

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M A. BUI | | NSTRUCTION 00 | (X3) DATE : COMPL | ETED | |
|--|--|---|---|---------------|---|---------|----------------------------|
| | | 155672 | B. WIN | G | | 04/18/2 | 011 |
| | PROVIDER OR SUPPLIER | | | 31869 0 | .DDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Pu what data the systemic | | | | (X5) COMPLETION DATE |
| | was healed). | the white sock (right heel | | | By what date the systemic changes will be completed: Ma 2011 | | |
| | time of the above she was aware of and indicated Reusually just cover they get cold. We debriding Reside bandaged the word entire foot with the washed her hand and left the resident. 2. The clinical | l record for Resident | | | | | |
| | # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: multiple sclerosis, diabetes mellitus, esophageal reflux, and hypertension. Physician orders, dated 2/13/10, indicated, "Metformin Tab 500 mg (milligrams), take 2 tablets (1000 mg) by mouth twice daily for diabetesMisoprostol Tab 200 mcg (micrograms), take 1 tablet by mouth three times daily for ulcer | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPI 04/18/2 | ETED | | |
|---|--|--|---|---------------------|--|------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE | |
| | take 2 tablets (three times da relaxantFort 200/ACT, inst alternating nos A physician or indicated, "T take 3 tablets (bedtime" Review of the 2/28/11 MAR Administration the resident di scheduled med Metformin 2 2/3/11, 8 A.M A.M.; 2/5/11, 2/6/11, 8 A.M A.M., 5 P. M Misoprostol 2/3/11, 8 A.M 2/4/11, 8 A.M P.M., 5 P.M.; | ical spr (spray) ill 1 spray in strils daily" rder, dated 2/19/10, rizanidine Tab 4 mg, (12 mg) by mouth at 2/1/11 through (Medication in Record), indicated d not receive the | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) M A. BUI | | INSTRUCTION 00 | (X3) DATE S COMPL | |
|---|---|--|------------------|---------------------|---|----------------------|----------------------|
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| | PROVIDER OR SUPPLIER | | , | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | • | |
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIENT REGULATORY OR P.M., 5 P.M. Tizanidine 2 2/3/11, 8 A.M. P.M.; 2/4/11, 8 2/5/11, 8 A.M. P.M.; 2/6/11, 8 | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 2/2/11 5 P.M., 9 P.M.; ., 1 P.M., 5 P.M., 9 3 A.M., 1 P.M.; ., 1 P.M., 5 P.M., 9 3 A.M., 1 P.M., 5 2/10/11 9 P.M. | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Medication No. "2/2/11 No s Misoprostol; 2 Metformin, M (Nurse initials Metformin, M (Nurse initials Misoprostol, T initials); 2/7/1 supply, (Nurse 2/7/11 Misopro (Nurse initials) | upply, Metformin, 1/5/11 No supply, isoprostol, Tizanidine isoprostol, Tiza | | | | | |
| | | 2011, MAR, Resident did not neduled Metformin a | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155672 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 | ETED | |
|--|---|--|---------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | p. with | STREET A | DDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | ı | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| TAG | total of 10 occ documentation recorded as no supply; Misop occasions with specifically reduce to lack of total of 21 occ documentation recorded as no supply. Review of the Nurse's Notes, documentation (Director of N (Medical Doct resident uses a of no available Metformin, M Tizanidine. Resident # 32' (blood sugar) 140; 2/5 - 90; 2/8 - 126. | asions with four also specifically at given due to lack of rostol a total of 14 asix documentation's corded as not given supply; Tizanidine a asions with five also specifically at given due to lack of a notifying the DON tursing), MD at a mail order pharmacy as supply of isoprostol, and as A.M. Accu Check on 2/3 - 161; 2/4 - 2/6 - 113; 2/7 - 120; | | TAG | DEFICIENCY) | | DATE |
| | 3/31/11 MAR | (Medication | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION 00 | (X3) DATE S | | | |
|--|---------------------------------------|--|------------|-------------------|--|----------|--------------------|--|
| ANDILAN | or correction | 155672 | A. BUI | | | 04/18/20 | | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | ļ | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | CHICAGO TRAIL | | | |
| HAMILTO | ON GROVE | | | NEW C | ARLISLE, IN46552 | | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) | |
| TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | JΈ | COMPLETION DATE | |
| | Administration | n Record), indicated | | | | | | |
| | the resident di | d not receive the | | | | | | |
| | scheduled med | lications: | | | | | | |
| | | | | | | | | |
| | Fortical 3/18 | 8/11, 3/26/11 | | | | | | |
| | | | | | | | | |
| | | 3/12/11, 1 P.M., 5 | | | | | | |
| | , , , , , , , , , , , , , , , , , , , | 3/13/11, 8 A.M., 1 | | | | | | |
| | , , | 3/14/11, 8 A.M., 1 | | | | | | |
| | , , , , , , , , , , , , , , , , , , , | 9 P.M.; 3/15/11, 8 | | | | | | |
| | i i | 5 P.M., 9 P.M.; | | | | | | |
| | <i></i> | I., 9 P.M.; 3/17/11, 8 | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | 5 P.M., 9 P.M.; | | | | | | |
| | <i></i> | 1., 1 P.M., 5 P.M., 9 | | | | | | |
| | f f | 5 P.M., 9 P.M.; | | | | | | |
| | · · | I., 9 P.M.; 3/21/11, 8 | | | | | | |
| | A.M., 5 P.M., | 9 P.M. | | | | | | |
| | The March 20 | 11, MAR, Nurse's | | | | | | |
| | Medication No | , , | | | | | | |
| | "3/12/11 1 P | , | | | | | | |
| | | ot given. Awaiting | | | | | | |
| | ` ′ | pharmacy(Nurse | | | | | | |
| | | 11 5 P.MZanaflex | | | | | | |
| | · · | aiting delivery from | | | | | | |
| | | urse initials), 3/12/11 | | | | | | |
| | 9 P.MZanaf | | | | | | | |
| | | very from pharmacy | | | | | | |
| | _ |), 3/13/11 Awaiting | | | | | | |
| | , | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 | ETED | |
|---|------------------------------------|------------------------------|-------|----------------|---|------|------------|
| NAME OF | PROVIDER OR SUPPLIEI | ₹ | - | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| нами то | ON GROVE | | | 1 | CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | TITLIOLE, IIV-0002 | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | Zanaflex deliv | • | | | | | |
| | signature), 3/1 | 5/11 5 P.M. Zanaflex | | | | | |
| | 1 | -awaiting delivery | | | | | |
| | (Nurse signati | are), 3/15/11 9 P.M. | | | | | |
| | Zanaflex is no | ot here yet-awaiting | | | | | |
| | 1 ' ` | se signature), 3/17/11 | | | | | |
| | 5 P.M. Zanafl | ex on order (Nurse | | | | | |
| | 1 '' | 11 9 P.M. Zanaflex | | | | | |
| | on order (Nur | se initials), 3/18/11 8 | | | | | |
| | A.M. Zanafle | x on order (Nurse | | | | | |
| | initials), 3/20/11 5 P.M. Zanaflex | | | | | | |
| | on order (Nur | se initials), 3/20/11 9 | | | | | |
| | P.M. Zanaflex | on order (Nurse | | | | | |
| | initials), 3/21/ | 11 Zanaflex on order, | | | | | |
| | not given (Nu | rse initials), 3/21/11 | | | | | |
| | Zanaflex on o | rder, not given (Nurse | | | | | |
| | initials)3/18 | /11, 8 A.Mout of | | | | | |
| | Fortical, on or | der (Nurse initials) | | | | | |
| | 3-18; 3/26, Fo | ortical N/A (not | | | | | |
| | available) en 1 | oute from pharmacy | | | | | |
| | (Nurse initials | s)" | | | | | |
| | | | | | | | |
| | The March 20 | 11, MAR, indicated | | | | | |
| | the Resident of | lid not receive the | | | | | |
| | scheduled For | tical a total of two | | | | | |
| | occasions with | n two documentation's | | | | | |
| | specifically re | corded as not given | | | | | |
| | 1 - | supply; Tizanidine a | | | | | |
| | 1 | casions with 13 | | | | | |
| | <u> </u> | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTI A. BUILDIN B. WING | | 00 | (X3) DATE S COMPL 04/18/2 | ETED | |
|---|---|--|-----------------|--------|--|------|----------------------------|
| | PROVIDER OR SUPPLIEF | 2 | 3- | 1869 C | DDRESS, CITY, STATE, ZIP CODE HICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | II PRE TA | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | | n's specifically ot given due to lack of | | | | | |
| | Notes, lacked notifying the I | March 2011, Nurse's documentation DON, MD, or family e supply of Fortical e. | | | | | |
| | 4/13/11 MAR Administration | n Record), indicated d not receive the | | | | | |
| | 4/6/11, 5 P.M. 4/8/11, 8 A.M | 4/3/11, 5 P.M.; ; 4/7/11, 5 P.M.; ., 5 P.M.; 4/10/11, 5 .8 A.M.; 4/12/11, 8 | | | | | |
| | Medication No. "4/6/11 Met 4/7/11 Metfor (Nurse signatu Metformin, No. 1) | 1, MAR, Nurse's otes, indicated, formin, No supply; min, No supply ure); 4/12/11 o supply (Nurse 3/11 late entry - | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPI 04/18/2 | LETED | |
|---|--|--|----------|---------------------|--|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | <u> </u> | 31869 C | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | 1 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (X5) COMPLETION DATE |
| | from CVS N/O 4/13/11 late er 4/9/11 (Nurse entry for 4/11/ (Nurse initials for 4/12/11 - Ninitials)" The April 201 the Resident discheduled Metoccasions with documentation recorded as no supply. Review of the 13, Nurse's Not documentation or family of no Metformin. A undated, to Dr 4/13/11 at 12:1"(Resident # Metformin sin Resident # 32') | April 1 through April otes, lacked in notifying the DON of available supply of a fax cover sheet, i. (name), faxed on 15 P.M., indicated, i. (32) has been without | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MU A. BUII B. WIN | DING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|---|---|--------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | D. WIW | STREET A | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR - 80; 4/11 - 20 | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 0; 4/12 - 157; 4/13 - | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | (lab test), drav | sive Metabolic Panel vn 2/1/11, indicated, igar level) 289 H level 64-105 | | | | | |
| | 12/2010, indic | s Care Plan's, dated ated, "Diabetes IIAdminister s prescribed | | | | | |
| | at 10:40 A.M., medication can local pharmac. South Bend fo medications w out or they can | hen a resident runs n pull the medication gency drug kit (EDK) | | | | | |
| | (Director of N nurse should n a resident does | 1:00 P.M., the DON ursing) indicated the notify the physician if s not get a he further indicated if | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|----------------------|--|------------------|---------------------------------------|--|---------|--------------------|
| THIS TETAL | or connection | 155672 | A. BUI B. WIN | LDING | | 04/18/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | PROVIDER OR SUPPLIER | | | 1 | CHICAGO TRAIL | | |
| HAMILTO | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG CROSS-REFERENCED TO THE APPROPRIA | | TE | COMPLETION DATE |
| | the resident us | es a mail order | | | | | |
| | pharmacy and | the medication is not | | | | | |
| | available, the | facility should get it | | | | | |
| | from the local | pharmacy. | | | | | |
| | | • | | | | | |
| | A memo from | the DON addressed | | | | | |
| | to Nurses rega | rding outside | | | | | |
| | pharmacy med | lication, dated | | | | | |
| | 4/12/2011, 9:3 | 5 A.M., indicated, | | | | | |
| | "Families an | d/or Residents are to | | | | | |
| | provide us wit | h the outside | | | | | |
| | pharmacy med | lications, but if they | | | | | |
| | fail to do so, it | is still our | | | | | |
| | responsibility | to make sure the | | | | | |
| | medications ar | re administered as | | | | | |
| | ordered by the | ir physician" | | | | | |
| ı | | | | | | | |
| | The Lippincot | t Manual of Nursing | | | | | |
| | Practice Handl | book, Third Edition, | | | | | |
| | indicated, "[| Diabetes | | | | | |
| | MellitusPhai | 0 | | | | | |
| | Interventions | .Oral hypoglycemic | | | | | |
| | agentsMetfo | rmin 1,000-2,550 mg | | | | | |
| | | divided doses with | | | | | |
| | mealsMultip | | | | | | |
| | SclerosisPha | rmacologic | | | | | |
| | Interventions | .Centrally acting | | | | | |
| | muscle relaxar | ntsto control | | | | | |
| | spasticity" | | | | | | |
| | | | | | <u> </u> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF CORRECTION | IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMP. 04/18/2 | LETED |
|--------------------------|--|--|--|--|------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET A 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| | Oral", undated resident refuse a medication reason in the reon the reverse medication reciphysicianina | on of Medications, I, indicated, "If a es or is unable to take write note as to nurses' notes and/or side of the cordnotify bility to take Document in the | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) M ¹ A. BUII B. WIN | LDING G | 00 | (X3) DATE COMPI 04/18/2 | LETED | |
|---|---|--|------------|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIER | | | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| F0312 SS=D | of daily living rece to maintain good r personal and oral Based on intervisions observations, the the necessary incresidents depend in a sample of 16. Findings include The clinical recoreviewed on 4/13. Resident #32's diwere not limited with suprapubic sclerosis, muscle urinary tract infe. During a tour on of the Center Un #2, she indicated and oriented time. During Medication 5:10 p.m. and 4/13 strong urine odor observations. Resobserved to have | ew, record review, and facility failed to provide continence care for 1 of 1 ent for incontinence care (c). (Resident #32) Example 11:00 a.m agnoses include, but to, neurogenic bladder catheter, multiple weakness, and history of ctions. 4/11/2011 at 10:25 a.m., it accompanied by LPN Resident #32 was alert es three. on pass on 4/12/2011 at 12/2011 at 12/2011 at 5:40 p.m., a was noted during both esident #32's bed was a wet beach ball sized sized amount of brown | F0 | 312 | F312 NO RESIDENTS WERE ADVERSLEY AFFECTED B' THIS ALLEGED DEFICIENCY. It is the policy and practice of facility to assist all dependent residents with their ADL care in order to maintain nutrition, grooming, personal a oral hygiene. For resident # 32 sufficient timexpired to preclude the immedicorrection of this finding. All residents dependent for incontinence care have the potof being affected by this finding. All nursing staff will be re-inson continence care as it affects resident's hygiene which includes but is limited to: timely change of linsoiled continent pads, resident garments to ensumaintenance of each resident's personal hygiene. The corrected action plan will that all dependant residents recommended. | good and he has iate ential erviced and hen, here, here, here, here is ensure | 05/18/2011 |

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155672 04/18/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 31869 CHICAGO TRAIL HAMILTON GROVE NEW CARLISLE, IN46552 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE continent care receive the necessary services in a timely manner to An interview was conducted with CNA #3 maintain good on 4/12/2011 at 6:20 p.m.. During the grooming and personal hygiene. interview, CNA #3 stated he assisted Resident #32 out of bed around 4:50 p.m., The Director of Nursing/Designee will observe at least four dependent to bring her to dinner. CNA #3 stated the residents resident was soiled due to incontinence. requiring continent care at least five CNA #3 stated he changed the bed, put days a week at various times and new linens and pads on the bed, different completed perineal care and placed a new shifts for 30 (thirty days) then five (5) residents monthly for two incontinence brief on the resident. months, then five (5) quarterly thereafter. An Interview was completed with alert and oriented Resident #32 on 4/12/2011 The Administrator/Designee will at 6:37 p.m. The resident stated she is review these findings weekly and submit his/her still wet from her suprapubic catheter observations to the Quality leaking. The Resident stated she did not Assurance Committee for further have an incontinence pad on currently. review and recommendations. This will be done An Interview was completed with the monthly for the first ninety (90) days then quarterly thereafter or until a DON on 4/12/2011 at 6:40 p.m. The 95% compliance threshold is met. DON indicated the wet area was due to perspiration. By what date the systemic changes will be completed: May 18, 2011 During an observation on 4/12/2011 at 6:42 p.m., CNA #3 came to the Resident's room and removed soiled sheets from Resident #32's bed. Review of Resident #32's Quarterly MDS (Minimum Data Set) Assessment, dated 2/9/2011, indicated Resident #32 needed extensive assist for transfer and she was frequently incontinent of bowel.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MI A. BUII | | ONSTRUCTION 00 | (X3) DATE COMPL | | |
|--|---|---|--------|--|---|--------------------------|------------|
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| | PROVIDER OR SUPPLIER | | 1 | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | 3.1-38(a)(2) | | | | | | |
| F0314 SS=G | a resident, the facinesident who enterpressure sores do sores unless the indemonstrates that a resident having precessary treatment healing, prevent insores from develop Based on observative record review, the prevent the development of 16. Residents: #55, #Findings include 1. Resident # 55's reviewed on 4/11 indicated diagnost osteoarthritis, ost hypertension. During initial tout 4/11/11 at 10:25 accompanied by was observed sittle. | ation, interview, and e facility failed to copment of Stage III or 2 of 3 residents in a 251 cs clinical record was /11 at 3:20 P.M., and ses of, but not limited to: reoporosis, and ar of the East Unit on | F0 | 314 | F314 NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Gro ensure residents who are admitt our facility without pressure are not develop them unless the individual's clinical condition demonstrates that they are unavoidable. For resident number 55 and 51 sufficient time has expired to preclude the immediate correction of this finding. Although the specialty cushion was immediately transferred and placed underneath the resident. 1. For residents 55 and 51 th | ve to ed to eas do | 05/18/2011 |

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|---------|---------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| | | | - | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | ę. | | 31869 (| CHICAGO TRAIL | | |
| | ON GROVE | | | L | ARLISLE, IN46552 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | l ' | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | TΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | | DATE |
| | | ambulatory with one | | | following wound treatments have been initiated. | ve | |
| | 1 ~ | h an acquired open area | | | 2. Low loss alternating flow | v air | |
| | to her coccyx. | | | | mattress | , un | |
| | | | | | 3. Wound treatments per | | |
| | LPN # 1 indicate | ed in an interview, at the | | | physician orders | | |
| | time of the above mentioned observation, | | | | 4. Wheelchair cushions | | |
| | the open area to | the coccyx was a Stage III | | | 5. Reviewed by a certified | , | |
| | (Full thickness the | issue loss. Subcutaneous | | | wound care nurse every four (4) weeks | , | |
| | fat may be visible | le but bone, tendon or | | | 6. Registered Dietician review | ews | |
| | muscle is not exposed). She further | | | | weekly and recommendations a | | |
| | indicated Resident #55 had a low air loss | | | | provided/communicated to staff | f | |
| | mattress (a specialized mattress that | | | | as needed. | | |
| | | ributes the fluctuation of | | | 7. Weekly weights | | |
| | | hen queried if Resident | | | 8. Occupational Therapist so9. Skin checks during show | | |
| | | lized seat cushion to aid | | | to be performed by both nurses | ers – | |
| | 1 ^ | the pressure ulcer, LPN | | | and CNAs | | |
| | | resident did have the | | | 10. Updated Braden scales | | |
| | | ion and was seated on it. | | | - | | |
| | _ | ld not be observed under | | | All residents receiving an accur | | |
| | | | | | Braden scale that identifies ther | | |
| | | e time because of the way | | | high risk for skin break down hat the potential to be affected by the | | |
| | the resident was | slouched in the chair. | | | finding | 1115 | |
| | | 1 . 10/06/11 2.52 | | | as well as residents requiring | | |
| | | dated 3/26/11 at 3:50 | | | extensive assistance or greater | | |
| | l ' | "During care CNA | | | (dependent residents) and 2 per | | |
| | , | ng Assistant) called this | | | assist as identified by the MDS. | | |
| | | ents bathroom. Open area | | | For wound provention all pay | | |
| | | occyx 1.5 x 0.5 x 0.3, | | | For wound prevention all new admissions will be assessed using | ng the | |
| | Duo Derm (padded dressing) applied, M.D. (Medical Doctor) notified, POA | | | | accurate Braden scale as a base | | |
| | | | | | to establish level of risk. For | | |
| | (Power of Attorney) notified." | | | | residents at high risk they will | | |
| | | | | | receive the following: | | |
| | A "Skin Care Management Form," dated | | | | 1 Adhama dha a | | |
| | 3/26/11, indicate | _ | | | A therapeutic type mattress that assists in reducing pressure | | |
| | 1 ′ | ndition developed after | | | mai assisis in reducing pressure | , | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|---|-----------------------------|------------|---------------|--|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED |
| | | 155672 | B. WIN | | | 04/18/2011 |
| NAME OF I | PROVIDER OR SUPPLIER | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | 1 | CHICAGO TRAIL | |
| | ON GROVE | | | <u> </u> | ARLISLE, IN46552 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE |
| TAG | | Data: 2/26/11 Type: | + | IAG | while | DAIE |
| | | Date: 3/26/11, Type: | | | resident is lying in bed | |
| | Pressure, Status I | , , , | | | 2. A basic pressure redistribu | tion |
| | Length/width (cm) (centimeters): 1.5 x 0.5 cm, Depth (cm): 0.3 cmColor: pink, Drainage (amount/type): scant | | | | cushion | |
| | | | | | 3. Enrolled in the red clock | |
| | , | | | | (turning and repositioning) prog | • |
| | | /11, Type: pressure, | | | 4. Registered Dietician review | " |
| | , | Length/Width (cm) 1.3 x | | | For all residents requiring exten | sive |
| | | mColor: pink, Drainage | | | assistance or greater (dependent | t I |
| | | lear to yellowDate: | | | residents) 2 person assist will re | eceive |
| | 4/9/11, Type: (bla | | | | the following interventions: | |
| | ` | m) 1.3 x 0.5, Depth (cm): | | | 1. A therapeutic type mattre | • |
| | 0.4Color: pink, Drainage (amount/type): | | | | that assists in reducing pressure while | |
| | 1 - | ent #55's "Skin Care | | | resident is lying in bed | |
| | _ | m," indicated she did not | | | 2. A basic pressure redistrib | ution |
| | have any previou | is pressure ulcers. | | | cushion | |
| | | | | | 3. Enrolled in the red clock | |
| | _ | on of wound care to | | | (turning and repositioning) prog4. Registered Dietician revious | |
| | resident # 55's St | age III pressure ulcer on | | | Kegistered Dietician reviewsHeal protection as deeme | • |
| | 4/12/11 at 2:05 P | .M., LPN #1 asked | | | necessary | |
| | Resident #55 to s | stand up from her recliner | | | | |
| | to help facilitate | the wound treatment. | | | The corrected action plan will e | nsure |
| | Resident #55's w | ound appeared to be | | | that residents who enter our | |
| | about the size of | a dime with a deep crater | | | facility will not develop pressur areas. | |
| | with a creamy ye | ellow center (slough) and | | | 340. | |
| | located at the coo | ccyx (base of the | | | Skin sweeps were complete | ed on |
| | | and sacrum). The old | | | May 3, 2011. Any areas identif | |
| | dressing removed | d by LPN #1 had a slight, | | | are receiving appropriate treatm | ent. |
| | | ain on it. It was observed, | | | | |
| | 1 * | pressure reducing seat | | | All Nursing staff will be | |
| | | in her recliner, but rather | | | re-inserviced regarding wound | |
| | | ir which sat vacant near | | | prevention | |
| | | 20 who was assisting | | | protocol. | |
| | | d she does not usually | | | Director of Namina /Davis | .:11 |
| | | #55, but whoever did, | | | Director of Nursing/Designee w | /111 |
| FORM CMS-2 | 2567(02-99) Previous Versio | | Y4C611 | Facility I | ID: 000427 If continuation sl | heet Page 38 of 72 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | A. BUIL | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/18/2011 | | |
|--|--|--|---|---------------------|---|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | |
| TAG | forgot to put her recliner before to recliner before to recliner before to the Resident #55 was 4:55 P.M., sitting East Unit dining her seat cushion was in her room at 4: the Director of National Resident #55 was cushion while up Resident #55's manual Market Ma | seat cushion in her ansferring her into it. s observed on 4/12/11 at g in her wheel chair in the room. She did not have in the wheel chair. The observed in the recliner 57 P.M. At 5:00 P.M., fursing confirmed s without her seat o in her wheel chair. nost recent quarterly Data Set) Assessment, dicated she was tinent of urine and needed of 1 for toileting. iated 10/05/10, indicated, ident #55) is at risk for evelopment R/T (related mobilityApproaches: 's (treatments) as a red Clock Program (turn ry two hours). Turn ide to side when in bed to ed pressure to bony (29/11: Low Loss Air4/1/11: Calcium Alginate reatment) with drsg er coccyx wound" | | TAG | review all residents to determin level of risk for skin breakdowr. Those identified at high risk we provided a therapeutic type mat a basic pressure redistribution cushion and enrolled in the red program. The Director of Nursing/Design will review at least 12 residents weekly for thirty (30) days then monthly for the next ninety day thereafter to ensure wound prevention interventions continuous place and to identify others where risk status may have changed since the last assessment. The Administrator/Designee will review these findings weekly as submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quart thereafter or until a 95% complethreshold is met. New therapeutic mattresses (20 all) that assist in reducing pressure and basic redistribution cushions have been ordered to ensure all residents receive the wound prevention intervention. Their arrival is anticipated beformay 18, 2011 but due to transportation, warehouse on harman provided to the provided | e a. ere tress, clock eee 12 s ue in ose nce Il ad he for he erly iance in n seat his | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|--|--------------------------------------|----------------------------|-------------------------------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 00 | COMPL | LETED |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| | | 1 | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | 1 | CHICAGO TRAIL | | |
| | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , and the second | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE. | COMPLETION |
| TAG | † | R LSC IDENTIFYING INFORMATION) | + | TAG | , | | DATE |
| | | of a pressure relieving seat | | | availability delivery could be delayed beyond May 18, 2011. | | |
| | cushion. | | | | delayed beyond May 18, 2011. | | |
| | | | | | By what date the systemic char | nges | |
| | 1 | nary Care Plan Progress | | | will be completed: May 18, 20 | | |
| | Note, dated 3/16 | 5/11, indicated, "Not | | | | | |
| | much motivation. Sits in common area | | | | Please refer to Exhibit 1 attac | hed. | |
| | and watches peo | and watches people. No mood behavior | | | FYI | | |
| | problems. Cooperative with care" | | | | Hamilton Grove administration | 1 | |
| | | | | | recognizes the increased numb | | |
| | A "Braden Scale for Predicting Pressure | | | | residents | | |
| | Sore Risk," dated 2/28/11, indicated a | | | | receiving a diagnosis of PVD. | | |
| | score of 15 (low risk) for Resident #55. | | | | effort to assure timely follow u | p, | |
| | | , | | | the medical director will | 1 | |
| | Review of the R | esident Assessment | | | communicate to the podiatrist t when a resident presents signs | | |
| | | ary (RAP), dated 9/25/10, | | | symptoms suggesting a new | 01 | |
| | 1 | essure ulcers triggered for | | | diagnosis, this information sho | uld be | |
| | 1 | ecause her bed mobility is | | | conveyed immediately to either | | |
| | 1 ` ′ | g her at risk for pressure | | | the primary care physician or | | |
| | 1 ^ | ent and she has a hx | | | medical director. They will the | | |
| | 1 | | | | determine whether follow up to is required to confirm and/ | esting | |
| | (mistory) or pres | sure ulcers in the past" | | | or treat the suspected diagnosis | , | |
| | 2 D | Lance Calon Front III 12 | | | or treat the suspected diagnosis | ·• | |
| | | tour of the East Unit on | | | The DON/Designee will review | v the | |
| | | A.M. while accompanied | | | podiatrist's clinical notes mon | 5 | |
| | 1 * | indicated Resident #51 | | | and communicate any new sign | ns or | |
| | | solation with MRSA | | | symptoms to the primary care physician/medical director for | follow | |
| | 1 ' | stant Staphylococcus | | | up treatment and/or | ionow | |
| | | quired stage III pressure | | | recommendations. | | |
| | | heel. Outside the room | | | | | |
| | 1 | ing 3 drawer cabinet | | | The Administrator/Designee w | | |
| | which contained gloves and gowns to be | | | | submit these findings to the Qu | | |
| | worn when providing care to Resident | | | Assurance Committee for revie | ew and | | |
| | #51. | | | | further recommendations. | | |
| | | | | | | | |
| | Laboratory repo | rts, dated 3/02/11 and | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE | | |
|--|---------------------------------------|------------------------------|--------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | IG | | 04/18/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| LIANAU TO | ON ODOVE | | | 1 | CHICAGO TRAIL | | |
| HAMILIC | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| IAG | | LSC IDENTIFYING INFORMATION) | | TAG | DETCIENCT) | | DATE |
| | · · | d the wound to the left | | | | | |
| | | #51 was positive for | | | | | |
| | MRSA. | | | | | | |
| | | | | | | | |
| | A "Change of Condition Form," dated | | | | | | |
| | 3/09/11, indicated, "Problem: MRSA to | | | | | | |
| | l ` ′ | nd. Interventions:2. | | | | | |
| | Contact Isolation | l" | | | | | |
| | Dutus 1 | C | | | | | |
| | During observation of wound care on | | | | | | |
| | | A.M. while accompanied | | | | | |
| | ' ' | apist (PT) #21, Resident | | | | | |
| | | d lying in bed. PT #21 | | | | | |
| | | ident and set her supplies | | | | | |
| | 1 ^ | stage III pressure ulcer | | | | | |
| | | s left heel. She removed | | | | | |
| | ı | which contained a | | | | | |
| | 1 ^ | osanguineous (thin and | | | | | |
| | - | lrainage) spot. The | | | | | |
| | | fy red dime-sized crater | | | | | |
| | l | eamy white tissue. No | | | | | |
| | l | st that results from | | | | | |
| | trauma) was pres | ent. | | | | | |
| | | | | | | | |
| | · · | dated 12/11/10 at 10:30 | | | | | |
| | I | st note indicating the | | | | | |
| | _ | the pressure ulcers to | | | | | |
| | | eels, "Res (resident) was | | | | | |
| | | sters on both heals (sic) | | | | | |
| | | oth are intact, both are | | | | | |
| | black in color." | | | | | | |
| | | | | | | | |
| | A "Doctor Progre | - | | | | | |
| | 12/17/10, indicat | ed, "Developed dark | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | | |
|--|---|---|------------|-------------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | G | | 04/18/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | CHICAGO TRAIL | | |
| HAMILTO | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | ` | oilateral) heels. ? friction. | | | | | |
| | ı | yExt (extremities): L | | | | | |
| | (left) heel with soft large hemorrhagic | | | | | | |
| | blister. No SOI (sign of infection). R (right) heel with flat, dried blister? | | | | | | |
| | | | | | | | |
| | unopened. No SOI. | | | | | | |
| | Dogidant #511a ar | | | | | | |
| | | nnual MDS (Minimum ment, dated 2/09/11, | | | | | |
| | 1 | d one "unstageable | | | | | |
| | 1 | ith suspected deep tissue | | | | | |
| | 1 ~ | onPressure ulcer length: | | | | | |
| | 1 * * | ers); Pressure ulcer | | | | | |
| | ` | Pressure ulcer depth: 0 | | | | | |
| | cm" | ressure dicer deptir. 0 | | | | | |
| | CIII | | | | | | |
| | A Care Plan, init | iated 2/24/11, indicated, | | | | | |
| | "Problem: (reside | | | | | | |
| | ` | sure ulcers, one on each | | | | | |
| | 1 ~ ^ | es:(3/17/11) cleanse L | | | | | |
| | 1 ^^ | ormal saline) or wound | | | | | |
| | ` | Santyl (chemical debrider) | | | | | |
| | 1 | en apply Calcium | | | | | |
| | | d with wound healing | | | | | |
| | | er with foam drsg | | | | | |
| | (dressing) bid (tw | | | | | | |
| | | • / | | | | | |
| | | | | | | | |
| | The "Change of | Condition Forms," | | | | | |
| | indicated the foll | owing: "12/11/10: | | | | | |
| | | Both heals (sic) have | | | | | |
| | intact blisters, bo | | | | | | |
| | | blisters to both heals | | | | | |
| | (sic), blisters are | intact with no drainage, | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | (X3) DATE | | |
|---|---|---|--------|--------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | 155672 | A. BUI | LDING | 00 | 04/18/2 | |
| | | 100072 | B. WIN | | | 04/10/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL | | |
| наміі та | ON GROVE | | | 1 | ARLISLE, IN46552 | | |
| | | | | <u> </u> | AILIOLL, III40002 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | * | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | | in color2/2/11: | + | | | | |
| | | | | | | | |
| | Problem: Abt (antibiotic)/ (left) heel2/11/11: Problem: Open area bilat | | | | | | |
| | | - | | | | | |
| | (bilateral) heel (s)3/9/11: Problem: MRSA to L heel wound" | | | | | | |
| | MRSA to L neel wound" | | | | | | |
| | A "Doctor Progre | | | | | | |
| | _ | reased d/c (discharge) and | | | | | |
| | | eel woundL heel with | | | | | |
| | ` ′ | with exudative base and | | | | | |
| | | | | | | | |
| | redness surroundingheel wound with infection" | | | | | | |
| | infection | | | | | | |
| | A "Doctor Progre | ess Notes," dated 3/16/11, | | | | | |
| | _ | right) heel healed. L heel | | | | | |
| | + (positive) MRS | | | | | | |
| | (positive) with | DA | | | | | |
| | A Nurse's Note (| dated 2/15/11 (no time) | | | | | |
| | indicated, "Tx | ` ' | | | | | |
| | • | at (bilateral) heelsRes | | | | | |
| | ` ′ | (diagnosis) PVD | | | | | |
| | ` ′ | ılar disease) bilateral | | | | | |
| | feet" | and discuse) official | | | | | |
| | | | | | | | |
| | Review of Reside | ent #51's diagnoses in her | | | | | |
| | | Ooctor Progress Notes, | | | | | |
| | , | , History and Physical) | | | | | |
| | | a diagnosis of PVD, | | | | | |
| | | atry Progress Note, dated | | | | | |
| | | ed PVD was circled as a | | | | | |
| | diagnosis for Res | | | | | | |
| | diagnosis for Nes | $\pi J 1$. | | | | | |
| | During an intervi | iew with Dr. (Name) on | | | | | |
| | _ | P.M., she indicated | | | | | |

000427

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/18/2011 | | | |
|---|---|---|---|---------------------|---|----|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE | |
| | REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #51 had a good pedal pulse. She further indicated, when queried about circulation in Resident # 51's lower legs, the right heel healed up without difficulty and the left heel should do the same as soon as the MRSA treatment is completed. She also indicated she did not give her the diagnosis of PVD, but saw it on the podiatry note. "The family has requested comfort measures only so I have not pursued an arterial blood flow study. That test would be the way to diagnose if she had PVD." Review of 40 clinical records in the facility indicated all of those residents had a diagnosis of PVD on their Podiatry Progress Note, but the PVD diagnosis did not appear on their History and Physical or admission diagnoses. 3.1-40(a)(1) 3.1-40(a)(2) | | | | | | | |
| F0323 SS=D | environment rema hazards as is poss receives adequate devices to prevent Based on record facility failed to | review and interview, the | F0: | 323 | F323 NO RESIDENTS WERE ADVERSLEY AFFECTED BY | | 05/18/2011 | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CO A. BUILDING B. WING | I 04/18/201 | | | | |
|---|--|--|---|--|----------------------|--|--|
| | PROVIDER OR SUPPLIER DN GROVE | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| | resident with a known history of leaning while in the wheelchair from falling for 1 of 4 residents reviewed with a history of | | | THIS ALLEGED DEFICIENCY. | | | |
| | falls in the sample of 16. (Resident # 85) Findings include: Resident # 85's closed record was reviewed on 4/14/11 at 8:00 a.m. The resident's record indicated diagnoses of, but not limited to; Alzheimer's disease, osteoporosis, glaucoma, congestive heart failure, cerebral vascular accident, | | | It is the policy of Hamilton Groensure that the environment is from | I | | |
| | | | | hazards. | | | |
| | | | | For resident number 85 sufficientime has elapsed which preclude correction of this alleged defice | de the | | |
| | | | | All residents receiving therapy seating recommendations for supportive | | | |
| | • | ic attacks, and seizures. | | posturing which may prevent f have a potential of being affect this | | | |
| | • | ed 4/1/11, 11:45 a.m., ent leaning forward in | | finding. The Director of Nursing/Desig | maa | | |
| | ` ' | , alarm sounded, fell /c before staff could | | will review all therapy recommendations daily at least 5 days a week for days then monthly thereafter to | sixty | | |
| | Nurses notes, dated 3/3/11 (no time), indicated n/o (nursing order) for OT (occupational therapy) for w/c | | | ensure therapy seating recommendation followed through. | | | |
| | positioning" | | | Nursing staff will be re-inservi regarding follow-up with thera recommendations. | | | |
| | indicated "Res (I w/c, repositioned | ed 3/5/11, (no time) Resident) is leaning in I by staff several time er for OT already | | The corrected action plan will that residents will receive prop services as recommended by the staff. | er | | |
| | · · | ed 3/7/11, 10 (not or p.m.) Res leans to (R) | | The Administrator/Designee w review these findings weekly a | I | | |

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

| l | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 04/18/2011 | | | |
|--------------------------|---|--|---|--|---------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | | | |
| | eval." Review of an Oct dated 3/7/11, indincreased risk of lateral leaning and leaningclinical observations/ass an 18 inch wide rests, no cushion extremities) were medially which, forward flexed poservices to position of falls from late which is not imposite interventions" Occupational Thafter the resident wheelchair, indince the objective of the work of the provent sacral singular for an intervention of the commended lower modified for an intervention of the commended lower modified for an intervent sacral singular for the commended lower locked. Eduleave breaks (sicunattended" | essments- pt presented in w/c with elevated leg present. Pt LEs (lower e dropping off leg rests when this happened, t at hips pt requires OT on her in w/c due to risk ral and forward leaning roving with nursing | | submit his/her observations to Quality Assurance Committee further review and recommendations. This will be done monthly for first ninety (90) days then quar thereafter or until a 95% completer or until a 95% completer. By what date the systemic char will be completed: May 18, 20 | the terly iance | | | |

000427

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|--|------------------------------|------------|------------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| | N 000/5 | | | 1 | CHICAGO TRAIL | | |
| HAMILIC | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , i | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | l ' | d "Problems: (Resident | | | | | |
| | l ' | for falls r/t (related to) | | | | | |
| | impaired safety awareness d/t her dx | | | | | | |
| | ' - ' | zheimer's dementia/ late | | | | | |
| | ` | bral vascular accident) | | | | | |
| | | (history) of falls in the | | | | | |
| | past" | | | | | | |
| | | | | | | | |
| | The Resident's pl | lan of care did not | | | | | |
| | address her leani | ng forward in her | | | | | |
| | wheelchair or any interventions put in | | | | | | |
| | place to prevent | the leaning. The | | | | | |
| | recommendation | s from Occupational | | | | | |
| | Therapy for a w/ | c tipped back on rear axle | | | | | |
| | or the low profile | e air cushion modified for | | | | | |
| | antithrust capabil | lities was not mentioned | | | | | |
| | in the Resident's | plan of care. The | | | | | |
| | Resident's record | did not indicate whether | | | | | |
| | the Resident had | received these items or | | | | | |
| | not. | | | | | | |
| | | | | | | | |
| | A form titled Fall | l Risk Assessment, dated | | | | | |
| | | 3/11, both indicated a | | | | | |
| | | tal score above 10 | | | | | |
| | | risk for falls. The form | | | | | |
| | 1 | desident had 3 or more | | | | | |
| | | eases present she would | | | | | |
| | | section. The Resident's | | | | | |
| | | score of 2. The Resident | | | | | |
| | | owing diagnoses CVA, | | | | | |
| | | Seizures. The correct | | | | | |
| | | these dates would have | | | | | |
| | _ | 4 instead of 9, putting | | | | | |
| | _ | Tinstead of 9, putting | | | | | |
| | her at high risk. | | | | | | |

000427

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/18/2011 | | | |
|---|---|---|---|---------------------|--|-----|----------------------------|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | F | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | TE. | (X5) COMPLETION DATE | |
| F0332 SS=D | Nursing on 4/15/regarding the lac prevent the reside falling from her withoutly checks we documentation in checks were combad fallen from to 3.1-45(2) The facility must emedication error ragreater. Based on observation interview, the facility medication error rational presidents observed during error. This resulted rate of 7.5 % (Residents of 7.5 % (Residents of 7.5 %). | k of interventions to ent from leaning and wheelchair, she indicated ere put in place. The adicated the hourly pleted after the resident the wheelchair. Insure that it is free of ates of five percent or In , record review and y failed to ensure a e of less than 5% for 2 of ed receiving medicatons . iicaton administraton and 40 opportunites for lin a medicaton error dent # 40, #32,) de: | F03 | 332 | F332 NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident # 40 and 32 sufficitime has elapsed to preclude immediate correction of this alleged deficit as it relates to: (1) eye drops, (2) coumadin, (3) Metformin. However, new medication was ordered immediately and received the sa day. | ent | 05/18/2011 | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|---------------|--|--|-------------|---------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED |
| | | 155672 | B. WIN | | | 04/18/2011 |
| NAME OF F | AD CAMPED OR GARDY IED | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 31869 (| CHICAGO TRAIL | |
| | ON GROVE | | | | ARLISLE, IN46552 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE |
| 1110 | | l instilled two drops | | 1710 | | DATE |
| | • | • | | | All residents receiving medicati | on |
| | 1 0 | into each eye of | | | have potential of being affected | by |
| | Resident # 40. | | | | this | |
| | | | | | alleged deficiency. | |
| | The clinical re | cord for Resident# | | | Hamilton's pharmacy will provi | de a |
| | 40, reviewed o | on 4/12/11 at 1:15 | | | Licensed Nurse to perform at le | ast 2 |
| | · · | d diagnoses of, but | | | supervised medication passes w | |
| | • | • | | | includes various routes of medic administration weekly on varying | |
| | not limited to: glaucoma, diabetes | | | | shifts for four weeks, then one | 15 |
| | mellitus, hypertension, and renal | | | | monthly | |
| | failure. | | thereafter. | | thereafter. | |
| | A1 | .1 1.4. 1 11/22/10 | | | The corrected action plan will e | nsure |
| | | der, dated 11/22/10, | | | that residents will receive the co | |
| | | lphagan P (eye drop | | | medication dosage per physician | n |
| | for Glaucoma) | sol (solution) | | | orders. | |
| | 0.15%, Instill | 1 drop in both eyes | | | The facility's contracted pharma | acy |
| | twice daily" | | | | will audit all medication carts by | y |
| | • | | | | May 18, 2011 to ensure both | |
| | The care nlan | for Resident # 32, | | | availability of medications and medication | |
| | dated 12/2010 | | | | dosages are dispensed accuratel | y. |
| | | | | | | |
| | | medications as | | | All nursing staff will be re-inser | |
| | prescribed" | | | | regarding the five R's of medica administration The right medic | |
| | | | | | the right dosage, the right reside | |
| | Interview with | LPN # 1 on 4/14/11 | | | the right time and the right route | |
| | at 11:40 A.M., | she indicated she | | | D. (OM : /D : | -11 |
| | gave the resident two drops in each eye but should have been one drop. | | | | Director of Nursing/Designee w observe at least 12 medication p | |
| | | | | | during the next 30 (thirty) days | ,usses |
| | | and the state of t | | | which includes various routes o | f |
| | Davious of the | Alphagan Dugalraga | | | medication | |
| | | Alphagan P package | | | administration on varying shifts three med passes quarterly | s then |
| | insert, printed | on 4/18/11 at 1:07 | | | unce med passes quarterly | |

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---------------|--|--|--------|--------------------------|--|-------------------------------|
| AND PLAN | OF CORRECTION | 155672 | A. BUI | | 00 | 04/18/2011 |
| | | 100072 | B. WIN | | DDDEGG CITY CTATE ZID CODE | 04/10/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL | |
| HAMILTO | ON GROVE | | | 1 | ARLISLE, IN46552 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| IAG | | · · · · · · · · · · · · · · · · · · · | + | TAG | thereafter. | DATE |
| | • | d, "No information | | | Those staff members found to b | e out |
| | is available on overdosage in | | | | of compliance with facility poli- | cy |
| | humans" | | | | will | |
| | | | | | be subject to one on one instruction/reeducation. | |
| | A facility police | | | instruction/recaucation. | | |
| | "Administration of Medications, | | | | The Administrator/Designee wi | |
| | Oral", undated, indicated, "Always | | | | review these findings weekly ar | |
| | adhere to the f | | | | submit his/her observations to the Quality Assurance Committee f | |
| | medication administrationright doseCheck medication label with | | | | further review and recommenda | |
| | | | | | This will be done monthly for the | ne |
| | order sheet" | | | | first | |
| | | | | | ninety (90) days then quarterly thereafter or until a 95% compli | ance |
| | | | | | threshold is met. | |
| | | | | | Dr. what data the aver | amia |
| | | nedication pass on | | | By what date the systection changes | emic |
| | 4/12/11 at 5:40 |) P.M., LPN # 2 | | | will be completed: N | Лау |
| | dispensed War | farin (Coumadin) 4 | | | 18, 2011 | |
| | mg to Residen | t # 32. | | | | |
| ı | | | | | | |
| | The clinical re | cord for Resident # | | | | |
| | 32 reviewed o | on 4/13/11 at 11:00 | | | | |
| | | d diagnoses of, but | | | | |
| | · · | • | | | | |
| | not limited to: | • | | | | |
| | · | ultiple sclerosis, | | | | |
| | diabetes mellit | tus, and hypertension. | | | | |
| | A physician or | der, dated 3/16/11, | | | | |
| | | ımadin 4.5 mg | | | | |
| | | po (orally) daily. | | | | |
| | | | | | | |
| | Recheck PT/IN | אוג (ומט וכאו וט | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|--|---|--------|---------------------|---|----------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | 31869 C | DDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | order, dated 3/ "Coumadin 4 thru Friday" Resident # 32' | second physician 24/11, indicated 4.5 mg 1 po Monday s care plan, dated | | | | | |
| | Coumadin 4.5 (Monday) - F | | | | | | |
| | at 3:30 P.M., s resident has be Coumadin inst 4.5 mg. LPN | the indicated the sen receiving 4 mg of sead of the prescribed # 2 did not indicate es this had occurred. | | | | | |
| | 4/12/11 at 5:40 | esident did not | | | | | |
| | 32, reviewed o | cord for Resident # on 4/13/11 at 11:00 d diagnoses of, but deep vein | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | li i | E SURVEY PLETED /2011 | |
|--|---|---|---------------------|---|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 31869 (| ADDRESS, CITY, STATE, ZIP COI CHICAGO TRAIL ARLISLE, IN46552 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | | ultiple sclerosis, tus, and hypertension. | | | | |
| | indicated, "M mg (milligram (1000 mg) by diabetes Interview with at 10:40 A.M. medications cathe local pharmor South Bendomedications wout or they can | an be ordered from macy in New Carlisle for back up when a resident runs n pull the medication gency drug kit (EDK) | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | A. BUILDING 00 C 04/ | | | (X3) DATE: COMPL 04/18/2 | ETED | |
|--|--|---|----|---------------------|--|--|----------------------------|
| | ROVIDER OR SUPPLIER | | | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL CARLISLE, IN46552 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΝΈ | (X5) COMPLETION DATE |
| F0333 SS=D | free of any signific Based on obse and record rev failed to ensure of significant related to the in Coumadin bein (Resident # 32 residents obsermedication passible). The clinical resulting and indicated resulting the continuity of the clinical resulting inclusions. The clinical resulting inclusions in the clinical resulting in t | rved during ss in a sample of 6. de: cord for Resident # on 4/13/11 at 11:00 d diagnoses of, but deep vein ultiple sclerosis, rus, and hypertension. der, dated 3/16/11, umadin 4.5 mg po (orally) daily. NR (lab test to | FO | 333 | F333 NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident number 32 sufficient time has elapsed to preclude immediate correction for the dates identifit this alleged deficiency. All residents receiving medicat have potential of being affected this alleged deficiency. For the date the surveyor receiventh the clinical record for resident number 32, the nurse immediately ordered coumadin from the pharmacy a received it within the allotted time of med (1 hour before or 1 hour after). There were no more interruptions in medication administration for the resident. All nursing staff will be re-insert regarding the five R's of medical administration. The right medical resident is a sufficient to the control of | ent ed on ion d by wed and pass his erviced eation | 05/18/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | |
|--|--|--|----------------------------|---------------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED | |
| | | 155672 | B. WIN | | | 04/18/2011 | |
| NAME OF I | DOLUMBER OR GURBU IER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF E | PROVIDER OR SUPPLIER | | | 31869 (| CHICAGO TRAIL | | |
| | ON GROVE | | | | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE | |
| IAU | | 24/11, indicated | | IAU | the right dosage, the right reside | | |
| | | | | | the right time and the right route | | |
| | | 4.5 mg 1 po Monday | | | The facility's contracted pharma | | |
| | _ | This indicated the | | | will audit all medication carts b | у | |
| | Resident had b | been receiving the | | | May 18, 2011 to ensure both availability | | |
| | wrong dose fro | om at least 3/16/11 | | | of medications and medication | | |
| | through 3/24/1 | 1 when the new | | | dosages are dispensed accuratel | y. | |
| | order was received. During medication pass on 4/12/11 at 5:40 P.M., LPN # 2 dispensed | | | | The corrected action plan will e | nsure | |
| | | | | | that residents will receive the rig | | |
| | | | | | medication in the right dosage. | | |
| | | | | | Discourse (NI series /Decises) | :11 | |
| | | madin) 4 mg to | | | Director of Nursing/Designee w review all residents receiving | 7111 | |
| | ` | madin) 4 mg to | | | coumadin | | |
| | Resident # 32. | | | | to ensure the physician orders | | |
| | | | | | accurately correspond to the | | |
| | Review of the | PT/INR (lab test), | | | available medication. This will be done | | |
| | indicated the f | following: | | | weekly for 30 days then monthl | v | |
| | | · · | | | thereafter. | , | |
| | 3/23/11 PT (P1 | othrombin time) 17.6 | | | The Administrator/Designee wi | 11 | |
| | H (high), norn | nal level 9.0-12.0 sec; | | | review these findings weekly ar | | |
| | 3/28/11 PT 25 | .8; 4/5/11 PT 28.5; | | | submit | | |
| | 4/13/11 PT 22 | | | | his/her observations to the Qual | · | |
| | | .υ | | | Assurance Committee for further review | er | |
| | Resident # 325 | s care plan, dated | | | and recommendations. This wi | ll be | |
| | | 1 / | | | done monthly for the first ninety | | |
| | · | ated, "3/24/11 | | | days then quarterly thereafter or | | |
| | Coumadin 4.5 | | | | a 95% compliance threshold is | met. | |
| | (Monday) - F | (Friday)" | | | By what date the systemic chan | ges | |
| | | | | | will be completed: May 18, 20 | | |
| | Interview with | LPN # 2 on 4/13/11 | | | | | |
| | at 3:30 P.M., s | he indicated the | | | | | |
| | | een receiving 4 mg of | | | | | |
| | 75-5-14 1105 0 | | | | | | |

000427

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

| | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE | |
|-------------------|-------------------------------------|---|--------|--------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| нами то | ON GROVE | | | | CHICAGO TRAIL ARLISLE, IN46552 | | |
| | | | | | AILIOLL, III40002 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | * | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | | tead of the prescribed | | | | | |
| | | # 2 did not indicate | | | | | |
| | _ | | | | | | |
| | how many times this had occurred. | | | | | | |
| | | | | | | | |
| | The 2010 Nursing Spectrum Drug | | | | | | |
| | Handbook, ind | licated, "Be aware | | | | | |
| | that Warfarin i | s a high-alert | | | | | |
| | | drugs expose patients | | | | | |
| | to an increased risk of significant | | | | | | |
| | harm when used in error" | | | | | | |
| | narm when used in error" | | | | | | |
| | | ANA 1 CNI . | | | | | |
| | | t Manual of Nursing | | | | | |
| | Practice Handl | book, Third Edition, | | | | | |
| | indicated, "[| Deep Vein | | | | | |
| | Thrombosisr | nonitor PTcheck | | | | | |
| | results before | giving next | | | | | |
| | ` | dose. Dosage may be | | | | | |
| | adjusted to ach | | | | | | |
| | elevation of th | | | | | | |
| | elevation of th | ese ieveis | | | | | |
| | A C 11: | .*.1 1 | | | | | |
| | A facility police | | | | | | |
| | | on of Medications, | | | | | |
| | Oral", undated | d, indicated, "Always | | | | | |
| | adhere to the f | ive rights of | | | | | |
| | | ministrationright | | | | | |
| | | nedication label with | | | | | |
| | order sheet" | indication moon with | | | | | |
| | oruci sileet | | | | | | |
| | | | | | | | |
| | | | | | | | |

000427

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 04/18/2011 |
|---|---|--|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER | | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| F0425 SS=D | residents, or obtaidescribed in §483 facility may permit administer drugs in under the general nurse. A facility must proservices (including accurate acquiring administering of a meet the needs of The facility must expressed on all pharmacy services Based on observices. | and biologicals to its in them under an agreement i.75(h) of this part. The unlicensed personnel to if State law permits, but only supervision of a licensed vide pharmaceutical g procedures that assure the in, receiving, dispensing, and ill drugs and biologicals) to each resident. Imploy or obtain the services macist who provides aspects of the provision of is in the facility. In the facility is the ordered ordered is the ordered is the ordered ordered is the ordered ordered is the ordered ordered is the ordered ordered ordered is the ordered ordered | F0425 | F425 NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Gro provide routine, emergency | ove to |
| | incarcation pa | | | medications and biological to a | .11 |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|---------------|---|--|---------|---------------|--|---------------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED |
| | | 155672 | B. WIN | | | 04/18/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | I | CHICAGO TRAIL | |
| HAMILTO | ON GROVE | | | NEW C | ARLISLE, IN46552 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE |
| 1710 | REGGE/HORT OR | ESC IDENTIF TING IN ORMATION) | | 1710 | residents living in our facility. | DATE |
| | Eindines in de | 1 | | | | |
| | Findings inclu | de: | | | For resident #32 sufficient time | has |
| | The clinical re | cord for Resident # | | | elapsed which preclude the immediate | |
| | | | | | correction of this alleged deficie | encv |
| | 32, reviewed on 4/13/11 at 11:00 | | | | as it pertains to the unavailabilit | |
| | A.M., indicated diagnoses of, but | | | | the | _ |
| | not limited to: deep vein | | | | following medications at the tin the inspectors survey: Metforn | I |
| | thrombosis, m | ultiple sclerosis, | | | Misoprostol, Tizanidine, and | 11111, |
| | diabetes mellitus, and hypertension. | | | | Fortical. | |
| | | | | | E D :1 | |
| | Physician orde | ers, dated 2/13/10, | | | For Resident # 32 Metformin Ta 500 mg (milligrams) Misoprost | |
| | indicated, "N | Metformin Tab 500 | | | Tizanidine Tab 4 Mg and Fortic | • • • • • • • • • • • • • • • • • • • |
| | mg (milligram | s), take 2 tablets | | | (spray) 200/ACT were immedia | itely |
| | | mouth twice daily for | | | reordered and received through | the |
| | · | oprostol Tab 200 mcg | | | resident's pharmacy. | |
| | | take 1 tablet by | | | All residents receiving medicati | ons |
| | | - | | | have a potential of being advers | ely |
| | | mes daily for ulcer | | | affected by this finding. | |
| | • | izanidine Tab 4 mg, | | | All nursing staff will be re-inser | rviced |
| | | (8 mg) by mouth | | | regarding the use of Hamilton's | I |
| | three times dai | ily for muscle | | | contracted pharmacy services. | I |
| | relaxantForti | ical spr (spray) | | | is, when a resident's medication supply is within 3 day of deplet | • • • • • • • • • • • • • • • • • • • |
| | 200/ACT, inst | ill 1 spray in | | | the nurse unit manager will be | 1011 |
| | alternating nos | | | | responsible for reordering a nev | v |
| | | • | | | supply of medications from the | |
| | A physician or | der, dated 2/19/10, | | | facility pharmacy. | |
| | | Fizanidine Tab 4 mg, | | | pharmacy. | |
| | take 3 tablets (12 mg) by mouth at bedtime" | | | | In addition, a letter was reissued | • • • • • • • • • • • • • • • • • • • |
| | | | | | resident and families who utiliz | e |
| | | | | | outside pharmacy services, reminding them that the Hamilt | on |
| | D : 01 0/1/11 1 | | | | reserves | |
| | keview of the | 2/1/11 through | | | | |

| T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | NSTRUCTION 00 | (X3) DATE S COMPL | |
|--|--|---|-------------|---|---------------------------------------|----------------------|
| | 155672 | A. BUI B. WIN | LDING IG | | 04/18/2 | 011 |
| PROVIDER OR SUPPLIEF | ! | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | |
| SUMMARY S (EACH DEFICIENT REGULATORY OR 2/28/11 MAR Administration the resident discheduled med Metformin a twith four documentation recorded as no supply; Tizani occasions with documentation recorded as no supply. Review of the 3/31/11 MAR did not receive medication do of two occasion documentation recorded as no supply. | (Medication not receive the dication doses: otal of 10 occasions amentation's corded as not given supply; Misoprostol a rasions with six n's specifically of given due to lack of dine a total of 21 n five n's specifically of given due to lack of dine at total of 3/1/11 through indicated the resident e the scheduled leses: Fortical a total ons with two n's specifically of given due to lack of dine at total of dine at total of 21 n five n's specifically of given due to lack of dine at total of 21 n five n's specifically of given due to lack of dine at total of 21 n five n's specifically of given due to lack of dine at total ons with two n's specifically of given due to lack of dine at total ons with two n's specifically of given due to lack of | | 31869 C | CHICAGO TRAIL | s fail on ss e d t all ill ensure | (X5) COMPLETION DATE |
| occasions with | idine a total of 33 n 13 documentation's corded as not given supply. | | | The Administrator/Designee wi review these findings weekly ar submit his/her observations to the Quality Assurance Committee of further review and recommendations. This will be | nd he or | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | COMPL | | |
|---|---|---|------------------|-------------------------------|--|---------|--------------------|
| | | 155672 | A. BUI B. WIN | LDING | | 04/18/2 | |
| NAME OF T | DROWNER OF CURRY YER | | P. WIIV | | DDRESS, CITY, STATE, ZIP CODE | 1 | |
| | PROVIDER OR SUPPLIER | | | 1 | CHICAGO TRAIL | | |
| HAMILTO | ON GROVE | | | NEW C | ARLISLE, IN46552 | - | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | • | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | DATE |
| | Review of the | 4/1/11 through | | | monthly for the | | |
| | 4/13/11 MAR | indicated the resident | | | first ninety (90) days then quanthereafter or until a 95% comp | - | |
| | did not receive | e the scheduled | | | threshold is met. | | |
| | medication doses: Metformin a | | | | By what date the systemic changes | | |
| | total of nine o | | | will be completed: May 18, 20 | - | | |
| | documentation's specifically recorded as not given due to lack of | | | | | | |
| | | | | | | | |
| | supply. | | | | | | |
| | | | | | | | |
| | During Medication Pass on 4/12/11 | | | | | | |
| | at 5:40 P.M., LPN # 2 indicated she | | | | | | |
| | | te Resident # 32's | | | | | |
| | | erefore the resident | | | | | |
| | did not receive | e the medication. | | | | | |
| | Interview with | LPN # 1 on 4/13/11 | | | | | |
| | at 10:40 A.M., | , she indicated | | | | | |
| | medications ca | an be ordered from | | | | | |
| | the local pharr | nacy in New Carlisle | | | | | |
| | or South Bend | * | | | | | |
| | | then a resident runs | | | | | |
| | - | n pull the medication | | | | | |
| | | gency drug kit (EDK) | | | | | |
| | box if it is ava | ilable. | | | | | |
| | On 4/12/11 of | 1:00 D.M. the DON | | | | | |
| | | 1:00 P.M., the DON | | | | | |
| | ` | ursing) indicated if es a mail order | | | | | |
| | | | | | | | |
| | pharmacy and | the medication is not | | | | | |

000427

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | li i | E SURVEY PLETED '2011 | |
|---|---|--|---------------------|--|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 31869 (| ADDRESS, CITY, STATE, ZIP COI CHICAGO TRAIL ARLISLE, IN46552 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | available, the from the local | facility should get it pharmacy. | | | | |
| | to Nurses regardance pharmacy medications are pharmacy medications are provided us with pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications are pharmacy medications. | dication, dated 5 A.M., indicated, ad/or Residents are to the the outside dications, but if they | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/18/2011 | | | | ETED | | |
|---|---|---|---|----|---|------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| F0431 SS=D | of a licensed phart system of records all controlled drugs enable an accurate determines that drugs and that an account of maintained and personance of the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession to the facility must store in locked compartry temperature control authorized personal keys. The facility must permanently affixed | mploy or obtain the services macist who establishes a of receipt and disposition of in sufficient detail to be reconciliation; and ug records are in order and all controlled drugs is riodically reconciled. Tals used in the facility must redance with currently onal principles, and include cessory and cautionary the expiration date when a State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only the local principles in the facility must redance with currently onal principles, and include cessory and cautionary the expiration date when a State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only the local principles in the facility must redained to | | | | | | |
| | Comprehensive Di Control Act of 1970 abuse, except whe unit package drug which the quantity | listed in Schedule II of the rug Abuse Prevention and and other drugs subject to en the facility uses single distribution systems in stored is minimal and a pe readily detected. | | | | | | |
| | Based on obse | rvation and | F043 | 31 | F431 | | 05/18/2011 | |
| | dispose of exp timely manner | facility failed to ired medications in a in 3 of 4 medication 2 medication rooms. | | | NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. | | | |
| | This deficient | practice had the Sect 5 of 80 residents. | | | For resident # 10, 27, 35, 39 and all dated medications cited were immediately removed from the | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COMI 04/18/ | (X3) DATE SURVEY COMPLETED 04/18/2011 | | |
|---|---|---|---|--|--|----------------------|--|
| | PROVIDER OR SUPPLIE | R | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) medication cart and appi | ould be PROPRIATE ropriately | (X5) COMPLETION DATE | |
| | Residents: # 46, | 10 # 27, # 35, # 39 # | | discarded. New medical provided by the facility's resident's pharmacy. | | | |
| | During inspection of the medication carts, the following expired | | | All residents receiving n have potential of being a this alleged deficiency. | | | |
| | | were observed: dication Cart on 15 P.M.: | | Facility's pharmacy will audit all resident medications to ensure none exceed the manufacture's recommended discard date. The corrected action plan will ensure medications dispensed, do not exceed the manufactures recommended discard date. | | | |
| | Xalatan 0.005 | 5: One bottle of 5% eye drops, fill date open date, discard | | | | | |
| | Xalatan 0.003 11/19/10, ope date 12/31/10 | 5: One bottle of 5% eye drops, fill date en date 2/2/11, discard b. | All Nursing staff were regarding the significal medication discard date necessity of removing medication cart and properly dispensure no medication that exceed the manufactories discard date. | | ce of the the the mem from the ing them to re dispensed | | |
| | A/14/11 at 2:10 P.M.: Resident # 27: one Metoprolol Tartrate (blood pressure) 50 mg (milligrams), fill date 3/16/10, discard date 3/16/11; two Furosemide (water pill) 40 mg, fill | | | DON/Designee will aud medications for outdated biologicals weekly for 6 monthly thereafter. The corrected action pla that all medications excemanufactures recommendate are removed and retimely manner. | d meds/ 0 days then n will ensure eeding the aded discard | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155672 | | | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 | ETED | | |
|---|---|---|---|---------------------|--|----------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE | |
| | five Oxybutyn anti-spasmodic 3/8/10, discard Spironolactone fill date 3/9/10 85 Lipitor (che date 3/16/10, o 92 Tramadol H date 4/20/09, o 74 Acetamino fill date 4/20/0 4/20/10; 17 Di pressure) 60 m discard date 3/20 Center Medica 4/14/11 at 2:25 Resident # 35: gel (eye drops 12/18/10, open bottle Brimonic | ation Cart # 2 on | | | The Administrator/Designee wereview these findings weekly a submit his/her observations to the Quality Assurance Committee further review and recommend. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% complete threshold is met. By what date the systemic charwill be completed: May 18, 20 | nd he for ations. he iance | | |
| | HCl (anti-hista | 71 Fexofendaine amine) 180 mg, fill use by 11/19/10; 124 | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|----------------------------------|--|------------------|----------------|---|---------|--------------------|
| | | 155672 | A. BUI B. WIN | | | 04/18/2 | 011 |
| | PROVIDER OR SUPPLIER | | | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | (X5) COMPLETION |
| TAG | | HCl 180 mg, fill date | + | TAG | DEFICIENCY) | | DATE |
| | $\frac{2}{10}$, use by | O / | | | | | |
| | | oride ER (potassium | | | | | |
| | supplement) 2 | 0 mEq | | | | | |
| | (milliequiviler | nts), fill date | | | | | |
| | 10/29/09, use 1 | by 10/29/10; 89 | | | | | |
| | ` | t) 0.125 mg, fill date | | | | | |
| | 2/25/10, use by | | | | | | |
| | | nonitrate ER (heart) | | | | | |
| | U , | e 11/28/09, use by | | | | | |
| | 11/28/10. | | | | | | |
| | West Medicati | on Room | | | | | |
| | Resident # 10: (insulin), fill d | one bottle Humalog | | | | | |
| | ` // | oiration date 12/2010. | | | | | |
| | | | | | | | |
| | | /14/11 at 2:45 P.M., | | | | | |
| | responsible for | cated the pharmacy is | | | | | |
| | medication car | | | | | | |
| | | She also indicated | | | | | |
| | | last checked the carts | | | | | |
| | on 4/11/11. | The second secon | | | | | |
| | | | | | | | |
| | The Director of | of Nursing (DON) | | | | | |
| | | /14/11 at 4:00 P.M., | | | | | |
| | pharmacy is re | esponsible for | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | IULTIPLE CO | ONSTRUCTION | (X3) DATE | | |
|--|--|---|-------------|--------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | | | 04/18/2 | 011 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| нами та | ON GROVE | | | | CHICAGO TRAIL ARLISLE, IN46552 | | |
| | | | | | AINLIGEE, IIN 4 0002 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · · | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | | · | | | | | |
| | checking the medication carts and the carts are checked monthly by | | | | | | |
| | | iceked monthly by | | | | | |
| | pharmacy. | | | | | | |
| | A HOT NO | n 1 | | | | | |
| | A "(Name) Ph | • | | | | | |
| | received on 4/ | 14/11 at 2:00 P.M., | | | | | |
| | from LPN # 1, | indicated, | | | | | |
| | "XalatanD | iscard 6 weeks after | | | | | |
| | date dispensed | l" | | | | | |
| | 1 | | | | | | |
| | An "Expiration | n Dates of | | | | | |
| | Medications" | | | | | | |
| | | • | | | | | |
| | · | ved on 4/15/11 at | | | | | |
| | 11:20 A.M., fr | | | | | | |
| | indicated, "C | Opthalmic (sic) | | | | | |
| | (eye)solution | nsexpire 3 months | | | | | |
| | after opening | ." | | | | | |
| ı | 1 6 | | | | | | |
| | (Name) nharm | acy, "Medication | | | | | |
| | ` / 1 | spection Report", | | | | | |
| | | • | | | | | |
| | | 14/11 at 5:00 P.M., | | | | | |
| | from the DON | | | | | | |
| | pharmacy chec | cked the carts last on | | | | | |
| | 4/11/11 and 3/ | 10/11. | | | | | |
| | | | | | | | |
| | A facility police | cy titled, "Medication | | | | | |
| | | Facility", dated, | | | | | |
| | _ | | | | | | |
| | January 2007, | | | | | | |
| | "Outdated1 | medicationsare | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | — COM 04/18 | (X3) DATE SURVEY COMPLETED 04/18/2011 | |
|---|---------------------------------|---|--|---|-------------------------------------|---------------------------------------|--|
| | PROVIDER OR SUPPLIE | R | 31869 (| ADDRESS, CITY, STATE, ZIP C CHICAGO TRAIL ARLISLE, IN46552 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | RRECTION HOULD BE APPROPRIATE | (X5) COMPLETION DATE | |
| | immediately r | removed from | | | | | |
| | 3.1-25(o) | | | | | | |
| | | | | | | | |
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PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | | (X2) MULTII A. BUILDING B. WING | | OO | (X3) DATE S COMPL 04/18/20 | ETED | |
|--|---|--|------------|-------------------|---|------|--------------------|
| | PROVIDER OR SUPPLIER | | 31 | 869 CI | DDRESS, CITY, STATE, ZIP CODE HICAGO TRAIL RLISLE, IN46552 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREI | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION |
| F0441 SS=D | The facility must el Infection Control F a safe, sanitary an and to help prever transmission of distractions of distractions of distractions in the facility must element of the facility element of the facility element of the facility element of the facility element of the facility element of the facility | stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted | TA | G | DEFICIENCY) | | DATE |
| | | ation, interview, and | F0441 | | F441 | | 05/18/2011 |
| record review, the facility failed to en proper infection control practices we | - | | | NO RESIDENTS WERE | | | |
| | ^ ^ | ring the debridement of a | | | ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. | | |

000427

| l i | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | | |
|-----------|--------------------------------------|------------------------------|------------|---------------------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155672 | B. WIN | IG | | 04/18/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| | N 000/5 | | | 1 | CHICAGO TRAIL | | |
| HAMILIC | ON GROVE | | | NEW C | ARLISLE, IN46552 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCE) | | DATE |
| | 1 1 | nureaus) infected and | | | For resident number 32 and | 51 | |
| | | for 1 of 3 residents | | | sufficient | 01 | |
| | | ith open wounds and | | | time has elapsed which prec | ludes | |
| | | nds after removing soiled | | | the | | |
| | | ncontinent residents (#32) | | | immediate correction of this | | |
| | in a sample of 16 | | | | alleged deficiency. | | |
| | Findings include | : | | | All residents who have their linens | bed | |
| | 1. During initial | tour of the East Unit on | | | changed have a potential of | being | |
| | 4/11/11 at 10:25 | | | | affected by this alleged | | |
| | accompanied by LPN #1, she indicated | | | | deficiency. In addition, residents who are i | n | |
| | | s in contact isolation with | | | isolation | | |
| | MRSA (methicil) | | | | also have a potential of being | g | |
| | · · | aureus) to an acquired | | | affected | | |
| | | e ulcer on the left heel. | | | by this alleged deficiency. | | |
| | | was a free-standing 3 | | | All nursing and therapy staff | were | |
| | | which contained gloves | | | re-inserviced on universal | | |
| | | worn when providing | | | precautions | | |
| | care to Resident | _ | | | including, but not limited to p | roper | |
| | care to resident | m31. | | | hand washing, contact isolation, p | roner | |
| | Laboratory repor | ts, dated 3/02/11 and | | | handling and transporting lin | | |
| | | d the wound to the left | | | to | | |
| | · · | #51 was positive for | | | prevent the spread of infection | on. | |
| | MRSA. | #31 was positive for | | | This corrected action plan w | ill | |
| | IVINSA. | | | | ensure | III | |
| | A IICharasa af Ca | andition Forms !! datad | | | that the facility practices will | | |
| | | ondition Form," dated | | | actively | | |
| | · · | d, "Problem: MRSA to | | | prevent the spread of infection | ons | |
| | ` ′ | nd. Interventions:2. | | | by following universal precautio | ne | |
| | Contact Isolation | l" | | | ionowing universal precaulio | 113. | |
| | During observation of wound care on | | | DON/Designee will observe | at | | |
| | | | | least 12 | | | |
| | 4/13/11 at 11:05 | - | | | nursing/therapy staff for prop | per | |
| | accompanied by | Physical Therapist (PT) | | | hand | | |

Facility ID:

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|---------------|--|--|---------|-------------------------|--|--------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED | |
| | | 155672 | B. WIN | | | 04/18/2011 | |
| | | | D. WII | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | - | | 1 | CHICAGO TRAIL | | |
| HAMII TO | ON GROVE | | | | ARLISLE, IN46552 | | |
| | | | _ | L | | 1 770 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA' | TE COMPLETION DATE | |
| IAG | | · | - | IAG | washing, handling and | DATE | |
| | · · | 1 was observed lying in | | | transporting | | |
| | | ressed the resident and | | | linens and contact isolation | | |
| | set up her supplies to debride the Stage III | | | | precaution | | |
| | pressure ulcer on | Resident #51's left heel. | | | compliance, weekly at variou | ıs | |
| | PT #21 washed h | er hands and donned a | | | times | | |
| | pair of gloves. Sl | ne did not wear a | | | and alternate shifts for the ne | ext | |
| | protective gown | and as she leaned over | | | 30 days, then nursing/therapy staff mo | onthly | |
| | ^ | on Resident #51 in her | | | for | Jiluliy | |
| | 1 | iform made numerous | | | the next ninety days, then 12 | 2 | |
| | 1 | sident #51's bedding. She | | | (nursing | | |
| | removed the old | • | | | therapy staff) quarterly there | after | |
| | | _ | | | – all, at | | |
| | | sanguineous drainage, | | | various times and alternate s | shifts | |
| | | d dead tissue from the | | | to ensure staff minimize the | | |
| | | essing the wound with a | | | transmission | | |
| | bandage, she disc | carded her gloves, | | | of infection. | | |
| | washed her hand | s, gathered her supplies, | | | | | |
| | and left the room | l. | | | The Administrator/Designee | will | |
| | | | | | review | | |
| | PT#21 was queri | ed, as she exited | | | these findings weekly and su | ıbmit | |
| | _ | oom, about the purpose of | | | his/her observations to the Quality | | |
| | | d in the cabinet outside | | | Assurance | | |
| | - | dicated the aides were | | | Committee for further review | and | |
| | | | | | re | | |
| | | them when they provided | | | recommendations. This will | be | |
| | continence care t | o Kesideni #51. | | | done | 0) | |
| | | | | | monthly for the first ninety (9 | U) | |
| | A facility policy | | | | days, then quarterly thereafter or u | ntil a | |
| | Precautions (Trai | | | | 95% | | |
| | Precautions)," ur | | | | compliance threshold is met. | | |
| | "Contact preca | utions will be used and | | | | | |
| | implemented for residents known or | | | | By what date the systemic | | |
| | suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by | | | changes will be | | | |
| | | | | completed: May 18, 2011 | | | |
| | | | | | | | |
| | _ | th the residentor | | | | | |
| | uneci contact WI | iii iiic iesideiii0i | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|--|--|-------------------|-------------------|--|-------------------------------------|------|
| | | 155672 | A. BUII B. WIN | | <u></u> | 04/18/2 | 011 |
| | PROVIDER OR SUPPLIER | | <u> </u> | 31869 (| ADDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | 1 | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ON SHOULD BE COMPLET HE APPROPRIATE | |
| TAG | indirect contact to surfaces or resider resident's room gown if you antice have substantial of environmental surresident's room leaving the room does not come in | ouching environmental ent-care items in the Gown: 1. "wear a cipate that clothing will contact with the resident, arfaces, or items in the 2. remove gown before, ensure that clothing contact with potentially vironmental surfaces" | | TAG | DETCENCT | | DATE |
| | 1 | _ | | | | | |
| | a medication pass p.m. and 4/12/20 urine odor was no observations. Re found to have a v sized area and a p | oom was observed during s on 4/12/2011 at 5:10 11 at 5:40 p.m A strong oted during both esident #32's bed was evet circular beach ball palm sized circular area taining brown matter. | | | | | |
| | Director of Nursi at 6:40 p.m The was due to perspi During an observ | s completed with the ang (DoN) on 4/12/2011 DoN stated that wet area direction. The state of th | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155672 | | (X2) MU A. BUIL B. WING | DING | NSTRUCTION 00 | (X3) DATE S COMPL 04/18/2 | ETED | |
|---|---|---|---------|---------------------|---|----------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WINC | STREET A 31869 C | DDRESS, CITY, STATE, ZIP CODE CHICAGO TRAIL ARLISLE, IN46552 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | Resident #32's be hands. CNA #3 in a plastic bag a dirty utility room with no signs of use. When asked CNA abruptly sta a chance." When typically wash his "I would go into A facility policy of Diseases," rev "C. Handwashi required to wash residentsD. Linhandle, store, pro- | | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM 04/18 | E SURVEY PLETED /2011 | | |
|--------------------------|---------------------------------|---|---|--|---|----------------------------|--|--|
| | PROVIDER OR SUPPLIEF | t | STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TRAIL NEW CARLISLE, IN46552 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | DRRECTION SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | | |
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